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Official Report of Debates (Hansard)

Monday 8 January 1996

Journal des débats (Hansard)

Lundi 8 janvier 1996

**Standing committee on
general government**

Savings and Restructuring Act, 1995

Health issues

**Comité permanent des
affaires gouvernementales**

Loi de 1995 sur les économies
et la restructuration

Questions concernant la santé



Chair: Jack Carroll
Clerk: Tonia Grannum

Président : Jack Carroll
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Monday 8 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Lundi 8 janvier 1996

The committee met at 0900 in the Senator Hotel, Timmins.

SAVINGS AND RESTRUCTURING ACT, 1995

LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Good morning, everyone, and welcome to the standing committee on general government hearings on Bill 26 and to Timmins. We're delighted to be here as a committee.

A couple of housekeeping things before we start. Summaries have been handed out to those members who were part of the hearings in Toronto before Christmas. You've been handed those by the research department.

Secondly, as far as time goes, every presenter has half an hour of time. They can use that time as they see fit. Any time left over at the end of the presentation for questions is divided evenly among the three parties and we start in rotation. We would start with the Liberal Party for the first set of questions. We tend to hold a fairly tight time line on the 30 minutes, so please don't be offended if the Chair happens to cut you off. We do have a lot of hearings and we are on a fairly tight time schedule, so those are the rules we play by.

As well, for those people who are here to listen to the hearings, we appreciate your attendance. It's nice to see you here. I'd just like to make you aware of the fact that the dialogue is between the people sitting at the table. I'm sure you will appreciate that and adhere to that.

NORTH EASTERN ONTARIO
PHARMACISTS ASSOCIATION

The Chair: Our first group this morning is from the North Eastern Ontario Pharmacists Association, represented by Calvin Brown, the president, Nancy Meyer, the secretary, Rachel Pineault, the private sector benefits manager and Sandra Hutty, a member from Sudbury. Welcome to our committee. The floor is yours.

Mr Calvin Brown: Our association over the past year has been working with local employers to achieve sustainable, long-term cost savings. This initiative is known as the Timmins project. In dealing with the private

sector in ongoing cooperative efforts, we have together developed unique ways in which to control and reduce drug plan expenditures. Some of these techniques are applicable to ODB, or Ontario drug benefit, and may lead to savings in that area. We would like to share our experience in the Timmins project and the success we have had in controlling and reducing drug plan costs for these employers.

We are not here to complain about the need for cost containment; rather we are here to offer concrete and workable applications to render long-term savings for the province we all live in. With the aforementioned goals in mind, we will look into four areas: days supply of medication, rational prescribing guidelines, deregulation and copayments.

The concept that must be understood and agreed upon by any group dealing with drug plans is that the overriding bulk of the prescription dollar is spent on the drug itself. For the private sector, this total is somewhere around 70% of the cost of the prescription. For ODB that percentage would be even higher.

This being the case, it makes common sense to target the cost of the drug as the main mechanism to achieve long-term savings. The government has made a start in this direction, but we see further opportunities to achieve savings and reduce wastage.

Several studies have recently pointed out the potential savings in reducing waste. In fact, an article in the last issue of Pharmacy Practice points out the huge savings to be had by reducing non-compliance by consumers. The study was conducted by the University of Toronto, the Addiction Research Foundation, the University of Guelph and the Toronto Hospital.

For example, assume the cost of Losec for one month is \$88. This medication should be dispensed only monthly. Currently the medication can be dispensed up to 100 days or three months. Thus, if three months were handed out and the patient for any reason changed medications or stopped using the Losec 10 days after getting the prescription, the loss to the Ontario taxpayer is \$234. The professional fee is the only variable in this equation and can in fact be used to determine the price breakpoint. If the medication were a new prescription, it should be given out only for 10 days in order to allow for an adequate trial. If the patient for some reason could not continue, the savings would be \$58.67. The savings on reduction in wastage would more than compensate for the small amount in increased professional fees.

We propose two things: First, if the cost of medications exceeds the professional fee for a year, dispense the medication in a monthly supply. Second, new medications which are expensive be given out in a trial prescription to

evaluate side-effects. This is one of the mechanisms we currently use to determine the number of days supply for those employers involved in the Timmins project.

Rational prescribing guidelines: The actual cost of medication and not the professional fee makes up the largest part of the average prescription. Over the last 10 years the cost of medication has increased at a rate of 18%, compared to the professional fee, which has been cut by 5.5%.

Perhaps we should be legislating the manufacturers of medications to post the actual cost of making a product and what markup they are placing on the product. This would allow all parties to know exactly where their money is going.

To attain real cost savings the focus should be on the drug entity itself. Pharmacists are the best source of unbiased drug information for both patients and physicians. This places pharmacists in the pivotal role of being able to recommend rational medications which are cost-effective.

For example, the cost of two capsules of Prozac 10 mg is \$3.27 while the cost of one capsule of Prozac 20 mg is \$1.67. If a prescription for Prozac 10 mg, two at bedtime, were written by the physician, you can see the vast cost savings which a pharmacist can generate by dialoguing. The pharmacist is probably the only health care professional who would be aware of this type of saving.

Prescribing guidelines which have already been set up for anti-infective and anti-hypertensive drugs should be looked at as a means of cost saving.

An example from the Anti-infective Guidelines for Community Acquired Infections follows: Otitis Media: Acute drugs of choice. As you can see, first-, second- and third-line antibiotics are listed as well as their cost per day.

In general, the older antibiotics should not be discarded for newer drugs unless efficacy is substantially improved, toxicity is reduced or overall effectiveness is greater. If there is no rational need to use Biaxin but the physician chooses the drug anyway, the cost would be 18 times more than either the first- or second-line choices.

We propose a tiered system of rational drug prescribing that can be guided using software that pays for the right drug at the right time in consultation with the patient, physician and pharmacist.

The guidelines we are speaking about are already in place and supported by ODB, family physicians, specialists, pharmacists, drug manufacturers and associations. All that is needed is a mechanism to ensure the use of these rational guidelines.

We feel this system can yield rational drug utilization as well as cost saving in excess of any proposed by the current changes.

Deregulation: Larger multinational drug companies with long patents remaining will likely raise their prices to the international standards, which are much higher than have been allowed in Ontario since 1986. The BAP, or best available price, system has worked effectively to keep drug prices down. Its destruction will mean higher costs for drugs. For a lot of businesses the increase in drug costs may lead to cancellation of drug plans. The result may be increased enrolment in the Trillium drug

plan. In turn, this will lead to increasing future costs for the Ontario taxpayer.

The following is a direct quote from a local employer in Timmins:

"We believe the present BAP system for non-ODB patients should be left in place. Our insurance carrier has already promised higher premiums for our employees' drug plan due to these anticipated higher wholesale drug costs. When our renewal comes up in February, we will cancel our drug plan component and have our employees apply for the Trillium drug plan. This will also apply for my wife's store as well as my partner's delivery company. If thousands of small employers across Ontario take this same route, it will raise the costs of the Trillium drug plan into the millions more than projected.

"It is this kind of flawed logic which permeates Bill 26. In order to save taxpayers from a financial fiasco, the bill should be taken back and reworked."

The new legislation will kill Bills 54 and 55, and some pharmacies will bill higher copayments to seniors than the currently negotiated professional fee. This will be especially true in towns with only one pharmacy and in northern communities where access is limited. The bill also opens up questions in terms of buying. If employers can negotiate directly with a drug company, only the largest will get a good price. The smaller companies will pay more, in order to subsidize deals for large employers. The Ontario taxpayer gains lost drug plans and small business closures. If we attempt to control drug use based on price competition, we are recreating the American system of health care. Perhaps before we do this we should have a close look at the per capita expenditures in the American system.

We propose that the BAP system is cost-effective and maintains an even playing field and therefore should remain unchanged.

0910

Copayments: Currently the OCP, the Ontario College of Pharmacists, a self-regulating body, sets standards of practice. What these standards do is ensure documentation of pharmacists' professional functions. This has put in place a mechanism to make our role as essential health care providers transparent. It has taken the recommendations of the Lowy commission and made them a reality. As pharmacists, we now document what we do for the Ontario taxpayer. This has put in place a mechanism to allow constructive dialogue with the OPA, the Ontario Pharmacists' Association, and government on reimbursement for the professional services we provide.

Deterrents created to limit access to pharmacists will potentially increase costs. Pharmacists are the most accessible and trusted health care professionals. If people can no longer afford to get their prescriptions filled, the increase in hospital costs could be staggering. We need rational use of the resources we have. Pharmacists are a cost-effective way to ensure understanding of prescriptions and to work with patients in getting the greatest benefit from all medications. We have the ODB plan in place because it is a very cost-effective way to reduce health care expenditures. In creating cost penalties for utilization of this cost-effective service, we are defeating its essential goal.

With respect to copayments for seniors over the income threshold, we believe there are other ways of implementing effective cost-sharing. As one example, the cost-sharing component can be set up as a monthly insurance plan, much like an insurance plan you buy when you travel out of province.

To summarize, we propose:

First, if the cost of medications exceeds the professional fee for a year, dispense the medication in a monthly supply.

Second, new medications which are expensive be given out in a trial prescription to evaluate side-effects.

We propose a tiered system of rational drug prescribing that can be guided using software that pays for the right drug at the right time in consultation with the patient, physician and pharmacist.

We propose that the BAP system is cost-effective and maintains a level playing field and therefore should remain unchanged.

The Chair: Thank you. We have about five minutes per party for questions, beginning with the Liberals.

Mrs Lyn McLeod (Fort William): I appreciate your presentation, and you've addressed two of the key concerns that we have as we look at the aspects of this bill that affect prescription drugs, one obviously being the deregulation of drugs and what that is going to do to the cost of drugs and the other being the whole question of the copayments. There are a number of questions around the ultimate cost of copayments and the effect that will have on access to pharmacists and to the drugs that are needed.

I'd like to then see if you've had a chance to look at some of the other parts of the bill that relate directly to pharmacists and the professional work of pharmacists. I'll just mention three areas, and if you've had a chance to look at any of the three, you might comment on it. In the interests of time, I won't make them separate questions.

One is that, in our reading of the bill, and it's actually section 23, the bill appears for the first time to give the cabinet, the politicians the ability to set conditions on the prescription of drugs, and as I understand it, this would be setting essentially government in place of the professional judgement of pharmacists and physicians as to what the appropriate prescriptions are. If you have any comment or concern about that, I'd appreciate your comments.

There is also the section of the bill that if there is any substitution for those who are on the Ontario drug benefit plan, the cost of the substitution would have to be paid for by the patient. I wonder, as pharmacists—and you've indicated in your brief that there are some situations in which an alternative to the least-expensive drug would be preferred for a patient—whether you would want to see some process in place to be able to provide a substitution for certain individuals.

Third is the fact that there are considerable powers to disclose information about the prescriptions you're giving to patients in order to implement the user fee program, whether that causes you concern as professional pharmacists.

So any or all three, if you have comments in the few minutes we have.

Miss Sandra Huty: All of these areas cause us considerable concern. First of all, by the cabinet taking over the power to decide what is or is not possible, by writing out any consultation, what they have done is remove any possibility of consultation, of advice. We have proposed in the past many ways of saving money for the government and they have just said, "No, we just don't want to listen to you any more." What they're doing is closing the door for any possible dialogue.

That causes great concern to us. We feel the patient should be able to choose or have some option for getting a product; for instance, if you have a patient who's allergic to some of the ingredients that hold a tablet together, even though the active ingredient may be the same as the product prescribed by the physician. They're not going to have that option any longer, so they will be paying out of their pocket, usually the poorest and least able to pay in most cases.

Freedom of information: Obviously, we feel that is a matter between the pharmacist and the patient, the physician and the patient, that there should be no way of identifying any information about a particular patient. That has been removed from the regulation so it causes us a great deal of concern.

Ms Frances Lankin (Beaches-Woodbine): Thank you very much and welcome. We appreciate your presentation. I have questions in three areas, so I'll try and go through them one at a time, but fairly quickly.

First of all, on your proposal with respect to a tiered system of rational drug prescribing, I can't tell you how much I agree with you. A lot of work has been done in the last number of years coming out of Lowy and a number of other studies, as I understand it from the time when I was Minister of Health. Everyone has said that the way to control the number of drugs, particularly that seniors are getting, is not by putting the user fee on, but by having good prescribing guidelines affecting the prescribing practice of physicians, so that they better understand and there's a closer link with pharmacists so the pharmacological expertise you have can be brought to bear in the patients' goodwill.

Can you tell me what effect you think the copayment will have, because we've heard members from the government say that too many seniors are getting too many drugs and that this \$2 copayment will help discourage that? Is that your understanding of the effect the copayment will have, and could you comment on that versus prescribing guidelines?

Mr Calvin Brown: Currently, copayments do exist in other provinces, and we've had a look at the effect it has had on utilization in other provinces. The most recent data come out of BC, and when they jumped their copay up, in fact it increased utilization, that they supply the medications, it went up, not down, so it didn't really do anything to discourage utilization; it just increased the amount of medications people were getting. So we don't really see any benefit to putting a copay into place.

Ms Lankin: If I can continue on with respect to copayments, the last day of hearings in Toronto we asked for a ministry representative to come forward, and Mary Catherine Lindberg, the assistant deputy minister, came forward. When I asked her if she would explain to us

how the copayment was going to be collected—we thought this was interesting—it seems as best I could understand the answer that that hasn't been worked out yet and there are a lot of details that are very, very sketchy, but it sounded like one of the ideas was that it would all be up to the pharmacist, and there was a suggestion that for those over the threshold, on the dispensing fee, the professional fee that you charge, some of you may waive \$2 of that in order to make up for the copayment that seniors would have to pay; it seems to me that then the burden falls on pharmacists to make up the money for the government as opposed to anybody else.

Have you been given any information or have you been told you're going to be responsible for collecting this? Have you thought about what it means in terms of administering this at the pharmacy level?

Miss Hutty: We have been given absolutely no information at all. That concerns us because we're getting a lot of questions from the public. What also concerns us is the fact that somebody at \$15,500 per year, for instance, will be paying \$2 a prescription, which in many cases will be difficult for them if they have 10 or 12 prescriptions a month. But then you jump to somebody who has an income of \$16,500 and they will be asked to pay the \$100 per year plus \$6.11 per prescription.

What we would like to know from the government is how it decides that \$1,000 difference in income decides that the patient has to pay several hundred dollars more per year. When you look at somebody who is paying \$6.11 per prescription and has 10 or 12 prescriptions a month, they're looking at something like \$74 per month as a deductible. Not only do we have no idea how we will be expected to go about collecting the deductible, but we would like to know how the government decides the income threshold and how it's going to go about determining that.

0920

Ms Lankin: My last question is with respect to the government's plan to deregulate the price controls on drugs for all the rest of the people in Ontario who aren't on the Ontario drug benefit plan. There's two parts, I guess, to this question.

The pharmaceutical industry says that competition will bring down the price of the drugs. You indicate you think if large companies and large purchasers and even large pharmacy chains negotiate a good deal, someone else has got to make up the difference. They point to pharmacists and suggest that the markup is an area that should be public, because the markup could be an area of differentiation. The pharmacists I've heard come forward before have said, "No, it wouldn't be us; it would be the drug companies." In fact you actually, I think quite fairly, say that in small towns with one pharmacy with a monopoly, that could be a problem too.

I just wondered if you could comment on that, because as someone outside the industry, I worry about both parts of this. I worry about the pharmaceutical industry price they charge and about what the pharmacist does with the markup and particularly in small, rural Ontario and northern Ontario.

The Chair: Unfortunately, there's no time left to answer the question.

Ms Lankin: Maybe you can answer in response to one of the government's questions.

Mrs Helen Johns (Huron): Thank you for being here today. We appreciate your time and obviously the thought that went into your presentation.

I'd just like to follow a different line of thought from what the previous two parties have been talking about. The Ontario drug benefit program has tripled in the last 10 years. Spending that the taxpayers of Ontario are paying for the ODB has moved from \$375 million to \$1.2 billion. It's really increased in the last 10 years, to the point that some people, taxpayers of Ontario, are wondering how we can control this.

Obviously, our reason for initiating Bill 26 is to try to manage the health care system. We believe that the only way we can do that is by some of the things we have proposed in Bill 26 when it comes to the ODB program, when it comes to copayments, elimination of no-substitute claims.

You basically have said you don't agree with any of those. Tell us how you would better manage the system to stop these escalating costs that are growing at the kind of rate they are, because we know they have been for the last 10 years.

Mr Calvin Brown: As we've already indicated, we had a number of proposals, the first being using the right drug at the right time for the right patient. That alone, as we indicated, with the overhead yields tremendous savings. In fact, we went through this proposal with a number of private employers in town and they agreed with us. We instituted those kinds of savings and we have generated reduction in costs for a number of employers.

It works. It's been put in place. We just need the consultation with the pharmacists, the physicians, and we need the patient in the loop as well. It's not that people are unwilling to look at alternatives; it's just that nobody has had the chance to propose them.

Mrs Johns: I guess I misunderstand you, because when I was reading along with you, I thought you were saying that was already in place, and we know the costs have been escalating up until this day.

Mr Calvin Brown: No, I said the system was already potentially in place. We have the information out there. What we need is a mechanism to use it. What we're doing is working with private employers at this point. We have had very little contact with the government. Any of the changes we've instituted locally are with private employers.

Mrs Johns: You talked about copayments and you basically said you didn't think that would stop the increase in dollars being spent in drugs. Can you talk about something that you think may help, or are we back to the bad example again?

Miss Hutty: As Calvin has already indicated, we have been working with a number of private corporations and the kind of things they have been using that have been used by the governments in British Columbia and Quebec, things like trial prescription programs. When a patient gets a new prescription for one of the more expensive products, it's given for a limited period of time, for instance, seven to 10 days, and then if that is

the appropriate medication for the patient the rest of the supply is given.

It was found in Quebec that in 50% of the prescriptions that second quantity was not picked up by the patient, which indicates that if, as happens here in Ontario at the moment, we give a three months' supply they use it for seven to 10 days and then throw away the rest. Medicine cabinet cleanups in various cities have demonstrated that very clearly. So the trial prescription program is one example.

Another one is that as indicated in antibiotic guidelines printed by the provincial government, you use the antibiotic in a certain sort of step method. You start with sort of an antibiotic that generally functions for these—in pneumonia, for instance, if there is an antibiotic-resistant pneumonia, then you go to a second level of antibiotic which is generally more expensive, but in 75% of the cases the initial antibiotic is the effective one, and you're saving \$60 to \$70 per patient per prescription by following the currently printed guidelines.

The Chair: We thank you for your presentation and your interest in our process.

Miss Hutty: We thank you for the opportunity.

Ms Lankin: Mr Chair, I'd like to place a motion before the committee.

Whereas there has been overwhelming public interest in Bill 26 and that 1,026 groups and individuals have requested to appear before the standing committee on general government for the out-of-town hearings which far exceed the 274 spaces available for hearings; I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged out of town; further, that this committee recommends that the three House leaders meet as soon as possible to discuss the issue.

I have copies available for the clerk.

The Chair: Out of respect for the people who are here to make presentations, do I have unanimous consent to deal with this at lunchtime?

Ms Lankin: Absolutely.

Mr Tony Clement (Brampton South): Mr Chairman, I'm wondering, have you made a ruling yet as to whether this is in order, given the motion that was passed by the Legislature to deal with the time allocation with respect to this committee and its position on January 29?

Ms Lankin: If it's of any assistance, Mr Clement, I was very careful in checking with the clerk's office to ensure that this motion was in order, as the previous ones that I moved in the first week of hearings, and that it was substantially different from those so that it wasn't a motion that this committee had already dealt with.

Mr Clement: Well, my question—

The Chair: Excuse me. The decision on the motion and the debate on the motion will take place at lunchtime out of respect for the people who are here being given their time to make a presentation. Can everybody agree with that? Agreed.

Mr Clement: Mr Chairman, by virtue of the committee, I also have the responses from the Ministry of Health

with respect to Ms Lankin's questions on December 21 and 22, 1995, including the copayment issue that she raised in her discussion with the former presenters. I'd like to table those.

The Chair: We'll have the clerk distribute those.

MICHEL LABELLE

The Chair: Our next presenters are from the Canadian Auto Workers, Michel Labelle. Welcome to our committee. You have a half hour to use as you see fit. Any time you leave for questions would begin with the NDP and be split evenly. The floor is yours, sir.

Mr Michel Labelle: First, I'd like to welcome you all to Timmins and maybe give an introduction of who I am and what I do. I'm an electrician. I'm a rank-and-file person who has taken an interest in Bill 26. I'm married, I have three children and we are also users of the health care system in Ontario. The brief that you have in front of you was prepared by myself and my wife, and the way it's laid out is that we've just looked at all the different acts that have been amended and we've basically broken them down into sections, looking at each amendment and coming up with interpretations.

The first amendment, in subsection 8(2), appointments to commission by Lieutenant Governor, is part of part I of schedule F, "Health Services Restructuring." It goes to the sixth amendment, sections 5 and 6, and the interpretation that we've come up with is these sections replace previous legislation and give the Minister of Health sole authority in the distribution of provincial aid to hospitals. He may unilaterally decide, at his discretion, which hospitals or medical facilities will receive grants, loans or financial assistance. He may impose, amend or remove any terms and conditions he considers appropriate in respect of the distribution of funds. The minister also determines the manner in which grants or loans are secured. He may reduce, suspend, withhold or terminate any grant, loan or financial assistance if he considers it in the public interest to do so. The Minister of Health may direct the board of a hospital as to what services they will provide, and increase or decrease these services. He may close or amalgamate any hospital or make any other direction related to a hospital that he considers in the public interest. These amendments also ensure compliance to the directions of the minister by the hospital boards.

0930

The seventh amendment: The interpretation is that investigators appointed by the Lieutenant Governor in Council report to the Lieutenant Governor or the Minister of Health and have the authority to investigate management and administration of a hospital, quality of care and treatment of patients or any other matter, again, the Lieutenant Governor deems relevant.

Section 9 is the directions to be followed. Again, like investigators, a hospital supervisor is appointed by the Lieutenant Governor in Council, is bound to carry out every direction of the Minister of Health, and reports to the minister. He has the exclusive right to exercise all the powers of the hospital board whether the hospital is public or is privately owned. He has unrestricted access to documents, records and information of the board and

the hospital. He has the same rights basically as the hospital administrator and the board.

Subsection 9.1 deals with public interest and no proceedings against the crown. We couldn't find anything in the document that defines what public interest is in the sense of the act. I guess it's left to the minister to decide what's in the public interest.

Interpretation: This amendment is one of the broadest in the document. It affords the Lieutenant Governor and the Minister of Health the right to consider "any matter they regard as relevant" in making a decision in the public interest regarding hospital or health care services. This amendment also specifies that no one has legal recourse against the crown or the Minister of Health in respect to sections 5, 6, 8 and 9 of this bill.

The 10th amendment deals with bylaws. We interpret it as such: It requires hospital boards to pass bylaws in line with the new legislation.

If we look at the 11th and the 13th amendment, it amends section 32. It gives supervisor powers over hospital boards and bylaws.

We interpret it as such: Section 32 gives the Minister of Health new powers to regulate the appointment of physicians. He requires hospital boards to submit their physician human resource plans to the ministry for approval. They must amend their plan as required by the ministry and are restricted to appointing physicians to the medical staff only in accordance with the approved physicians' human resource plan.

The 14th amendment: Where hospitals cease to operate, there are no hearings or protection from liability.

We interpret it as such: In cases where hospitals cease to operate—a decision of the hospital board or the Minister of Health—the minister reserves the right to reject the application of a physician for reappointment, to revoke the appointment of any physician or to cancel or alter the privileges of any physician. Doctors are barred from legal action against owners or operators of hospitals in subsection 44(4). We have to wonder exactly what that's going to bring to the quality of health care, especially in areas like northern Ontario, should the minister decide to exercise some of these wide-sweeping powers.

Section 15.4 goes from notice to no right to appeal, temporary control, authority of the minister, appointments; it talks about termination of order, repairs and recovery of costs.

Interpretation: The Minister of Health may at any time unilaterally revoke any private hospital's licence. He may make this decision based on financial considerations or any matter he deems relevant, with no prior notice to the licensee. He is protected under section 15.4 against any legal recourse for his actions. He also has the right to temporary control of any hospital for which he has revoked a licence and legal access to payments for repairs to the hospital from any person or persons to whom the licence was issued. Again, there are ample provisions for legal protection for the Minister of Health.

Part IV is Amendments to the Independent Health Facilities Act.

Interpretation: I will not list all of part IV but comment on it as a whole. The act broadens the term "facility fee" to include any segment of service that the minister

redefines. Independent health facilities would be allowed to charge fees over and above what is now covered by insurance to certain persons defined by regulation. The minister could, through regulation, include any for-profit independent facilities and effectively open the door to a two-tiered system. Extra billing for insured persons could result if the present uses of independent health facilities are expanded.

That concludes schedule F.

Schedule G: There are some amendments to the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act.

Part I is amendments to the Ontario Drug Benefit Act, and there are various amendments there. We've just interpreted all the way through schedule G. Although schedule G is not listed in its entirety, I will comment on many parts of the schedule. It amends the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act, 1991. This legislation takes the words "user fees" and spells them "copayments."

Part II is the Prescription Drug Cost Regulation Act. The 19th amendment: "The title of the Prescription Drug Cost Regulation Act is repealed" and substituted with the "Drug Interchangeability and Dispensing Fee Act."

Interpretation: This is an example of this government's feeble attempt to disguise new pieces of legislation by changing the name of an old one. The cost regulation of drugs no longer exists; it is gutted. This means that Ontario will become the only province that does not regulate drug prices. Schedule G allows for the substitution of brand-name drugs with generic drugs. Should a generic drug not be available to a patient where the Minister of Health has accepted it as a substitute for the name brand, the patient will be required to pay the difference between the price of the generic drug and the brand name. The minister will abolish the 10% to 20% markup on drugs and the Ontario drug benefit dispensing fee and set new regulations not yet disclosed. We have no part of knowing what the regulations will be.

If we go through the rest of the amendments, which are many, it brings us to the interpretation of those regulations in schedule H. Schedule H gives a new definition to the term "eligible physician." It gives the minister powers to restrict the number of eligible physicians in any areas of the province and imposes a moratorium on new eligible physicians.

Schedule H also redefines "insured services." It allows the Minister of Health to dictate insurable medical services with no consultation with medical professionals. Medically necessary services are also not spelled out in this bill. The minister is allowed to establish the conditions and limitations for insurable services and set levels for OHIP. There are factors such as geography and the physician's experience that will determine the fee payable.

The regulation system has dangers of delisting medically necessary services in attempting to find cuts. These decisions should be left in the hands of the Ontario Medical Association through a negotiation process with the government. The unilateral powers this legislation will give to the Minister of Health are undemocratic. He

is in no way qualified to make such decisions. It is an insult to our health care professionals to attempt to strip them of the consultation process. This legislation could open doors to a two-tiered health system in Ontario.

Schedule I kind of backs up what I said on schedule H. This new law strips the Ontario Medical Association of all its negotiated agreements and negotiating rights. It also overrules any judge's decision, award or order if it is contrary to the law.

In summary, the "common sense" government, with its Common Sense Revolution, states, in the introduction of your CSR: "It's time for us to take a fresh look at government. To reinvent the way it works, to make it work for people. While many goals remain important to us—creating jobs, providing safe communities, protecting health care...." etc—I'll just go from quote to quote. "Total 'non-priority' spending will be reduced by 20% in three years, without touching a penny of health care funding," page 3, item 2. "We will not cut health care spending. It's far too important." That's on page 7 of your CSR. "For the professionals within our health care system, this means freedom to find more efficient ways of spending without worrying that government will siphon their savings off into other programs," page 8. "Health care, law enforcement and classroom funding won't be touched"; that's on page 19. "We are ready to listen, to learn and to work with anyone who wants to join us and who can show us more creative, more effective ways to end waste and duplication." That's part of the summary of the CSR. "We will provide the people of Ontario with better for less," page 3.

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Are copayments and user fees better or less? Already we have seen massive cuts to our health care system. And to top it off, this promise: "Under this plan there will be no new user fees." Lies again, and again, nothing but betrayal of trust and lies.

It took years of painstaking work, trial and error to formulate legislation, with changes and amendments coming slowly. Progress takes time. When you rush, you make mistakes. It is irresponsible at best and dangerous at worst for any government to attempt to bring massive changes to our health care system without consulting health care professionals as to what impact it will have on the quality of that care.

What concerns me most, and I think I speak for many people, is the dictatorial nature of these amendments. This bill is an attempted assault on Ontarians. It threatens our rights by giving potential access to private information. There is a blue blanket that covers our province today. We have felt it smothering us under unworkable labour legislation. This blanket is hand-woven, and it's hand-woven with threads of dictatorship.

In closing, if this is an exercise in futility, if these hearings are only to appease the outcry, if despite these hearings the PC Party follows through with this omnibus bill without listening to Ontarians, take notice all the way to Queen's Park that we will start a revolution, a true "common sense" revolution, to educate the people of Ontario. We will work in earnest to thwart your efforts at changing our province from a place to grow to a place where no one wants to go. We deserve better than your

government is telling us is a "common sense" approach to good health care.

Thank you for your consideration.

The Chair: Thank you very much. We've left just under five minutes per party for questions, beginning with the NDP.

Mr Gilles Bisson (Cochrane South): Mr Labelle, I just want to pass on the comment that there's an extreme amount of research in this document and I would thank you and whoever helped you, because there's a lot of detailed look at the actual legislation and amendments. I think I would want to first of all speak on behalf of at least our members of the caucus here who were looking at it, saying, "Thanks for the insight into this."

I want to go to one point really quickly, and I'll pass on to Mr Wood here from Cochrane North. One of the things that you allude to in your presentation—you go through a whole explanation of basically what the bill does in regard to the health care sector—is to take the power out of the hands of local decision-makers, be it hospital boards, hospital administrators etc, the model of where we try to put decisions at the local level in order to respond to what's happening within our communities, to where it is possible that a minister can take over complete control of a hospital or a hospital board.

You talked about dictatorship. I'd like you to maybe expand on that a bit. The government is saying it needs the tools. They've got to be able to balance the budget; they need to eliminate the deficit. They're saying this bill is all about tools in order to do that. Is the toolbox needing, in your mind, to be that heavy, giving that kind of power to the minister, or should we be trying to find a way of working with communities?

Mr Labelle: I think that Timmins may be a good example of the way the system does work. We've had two hospitals that the district hospital councils here have closed on their own. They didn't need interference from the provincial level to do it. They saw the need, they saw that these hospitals were redundant in nature, and they amalgamated them on their own with the Timmins and District Hospital.

Right now we're just looking at the health part of the bill. If you take a look at all of Bill 26, it doesn't just include health, now, does it? It goes into municipalities, it touches all kinds of different areas that are also trying to bring these same wide, sweeping ranges of powers to different ministers with portfolios. I don't believe Ontarians need to have that kind of interference in their municipalities, in their health care system or any other system for that matter. We elect officials, boards are appointed by those officials or elected by the people, and I think that process works fine. I don't think we need to fix anything that's not broken.

Mr Bisson: One of the things you alluded to—you pointed it out, and it's not one of the things a lot of people talk about—presently, if I'm unhappy with the decision made by my local board, I can go and talk to my local board member, the administrator etc. One of the things this bill does, in the event that the minister takes over the running of the board, is that he or she is immune to any kind of action by a community and can't even be sued. How do you feel about that?

Mr Labelle: In my mind, what it brings to mind is that this is a kind of bullying tactic, that next thing you know, we're going to be told unilaterally how to do things, and if you don't play the game the way the minister may want it to play, it can open the doors to discrimination, it can open the doors to making decisions that are not necessarily in the public's interest. There's no definition of what the public interest is in the bill, to begin with. I believe that's something that should be looked at and definitely outlined, because people have the right to know what is in the interests of the public. That's a pretty broad term and easily misinterpreted or misused. The thing just gives too much power to one man or a series of people who can decide unilaterally what they're going to do with communities or health care and so on and so forth.

Mr Len Wood (Cochrane North): Thank you very much for an excellent presentation. On your last half of the page you're saying that it took years of painstaking work and trial and error to develop legislation, whether it be the health field or whatever, and by rushing through with the bully bill we see here, there can be a lot of mistakes. From what I can gather, the government is saying that it needs Bill 26 and it needed Bill 7 and it needed this to pay down the deficit. But in reality what they're looking at is a 30% tax break that they want to give to the people, and they're saying that's going to create employment. Do you see any employment being created with Bill 26?

Mr Labelle: I know there's some restructuring that is mentioned that's part and package of the bill. The restructuring may be necessary, but the biggest thing I see are some measures like files disclosed, personal files disclosed to whoever, the minister, and the minister can use them as he sees fit. Where does that save money? Where does that happen? What happens there?

As far as saving, the CSR always promised there would be no cuts to health care, there would be no spending cuts at all to the health care system and they were going to look at other avenues on saving this money.

Now, if you're going to be cutting a total of \$6.7 billion to the deficit, or the deficit spending, in the next three or four years to have to borrow another \$6 billion to give us a tax cut, why don't you just quit the running around and forget the tax cut and maybe concentrate on employment? Because I think the real problem in Ontario is not so much our health care, and it's not so much some of the social programs we enjoy. I believe the reason we see deficits going up is because of unemployment in Ontario. If you want to take people off welfare or reduce their benefits, how about you reduce them all the way, 100%, by supplying them with a good job?

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The Chair: For the government, Mr Clement.

Mr Clement: Thank you very much for your presentation, Mr Labelle. You've obviously spent a lot of time, and your wife has, going through this legislation—

Mr Labelle: That's right.

Mr Clement: —which I think is illustrative that people can come forward and speak to this committee and have time to dissect the legislation, as you have. It won't come as any surprise that you and I disagree on

some of your presentation, and in fact it's funny how things work, but I don't think the CAW, at least the union leadership, has agreed with the government much since June 8, although I had a number of CAW voters in my riding who seemed to see the need for some real change from the status quo, which wasn't working for anybody.

Some of the generalizations you engage in in your presentation do concern me a bit, because I think they're leaving an untoward impression for this committee. You just finished saying that personal files under our section can be used by the minister and disclosed as he sees fit. In fact, if you read the legislation, there are constraints on the minister's power to disclose or use that information, just as there are under the current legislation.

You mention the Common Sense Revolution document and the fact that you interpret it as meaning that somehow we're going to keep the exact status quo in health care when in fact our commitment was to keep the funding the same at \$17.4 billion but there have to be some, in some cases, radical changes in the health care system, just as there have to be some quite extensive changes in other parts of the way we govern ourselves and participate in this province.

Let me ask you this question: Do you think your colleagues in the CAW, your neighbours, your friends, your relatives, are absolutely satisfied with the status quo in health care, the way it's delivered in Timmins and the surrounding area?

Mr Labelle: I hope not. I hope that everybody would work towards making things better, using smarter ways to get them accomplished.

But what we see here is, I don't think my friends at the CAW would think the dictatorial measures that this bill allows ministers are such a good idea either. I don't think our buddies at the CAW would say it's okay for a minister to be able to have the unilateral power to shut down any hospital he feels is necessary to shut down in the public interest. First off, I think my friends out there and anybody who knows me would know that we definitely want a definition as to what public interest would mean in such a case, and Bill 26, the omnibus bill, is absent of that.

And as far as when you made reference to the Common Sense Revolution, I'm sure the promises were made that not a penny would be cut. In your last budget, there was a fair amount of money cut from the budget.

Mr Clement: And a fair amount of money reinvested as well, so the whole idea is to—

Mr Labelle: Over the four years, right?

Mr Clement: The whole idea, sir, just so you know and are aware of what the government's intentions are—

Mr Labelle: Oh, I know.

Mr Clement: The whole idea is to restructure the health care system so that we can give value to the taxpayers and also assist patients in need, and that means you have to rejig things. You can't keep spending on the things that don't make sense and then increase the spending on things that do make sense, because we'll all be in the poorhouse. So I think that's the government's intention, but I want to assure you that that's the way we're going on this.

In terms of the minister's power, because you spent a lot of your time in your presentation on that, if you look at some of the other provinces, and we've had some evidence to this effect, in New Brunswick they completely shut down all of the hospital boards and ran them out of the Ministry of Health. We're not proposing that. We're proposing that the boards should stay in place unless there are very, very extraordinary circumstances, and we want to work with the boards, but, ultimately, somebody has to make a decision. If no one gets to make a decision, then everything stays the same and we continue to pile up expenses and costs which are costing us but aren't delivering the health care that we need.

Don't you agree that ultimately it should be the elected person, the Minister of Health, who ultimately has to be accountable for the decisions on behalf of Ontarians?

Mr Labelle: On what level? You mean to tell me that the Minister of Health in the province of Ontario becomes the sole owner of all the hospitals or the sole facilitator of all the hospitals in Ontario? Is that what you're saying?

Mr Clement: Not at all. That's exactly what I'm not saying.

The Chair: Okay, thank you very much, Mr Clement. Just before we go to the next question, I would appreciate it if the dialogue between the questioner and the answerer be left just a two-person dialogue, mutual respect for one another, so we all hear the answers. Okay, the Liberals.

Mr Frank Miclash (Kenora): First of all, Mr Labelle, thank you very much for a very comprehensive presentation to us this morning. You quoted a number of times from the Common Sense Revolution. I have another document in front of me. It's called A Voice for the North, and it's a Report of the Mike Harris 'Northern Focus' Tour. It suggests, "We need answers—not made-in-Toronto policies, but solutions based on input and ideas from the people who live and work in the north." This is a document drafted in January 1995 and it was floated around northern Ontario quite a bit in June 1995, during the election, of course.

It goes on to say, "Recognizing the special needs of people in the north, we will give northerners a direct say in changing the Ministry of Health's planning and resource allocation so that it includes more consideration for northern priorities and conditions."

Mr Labelle, do you know of any group or organization that was consulted during the drafting of Bill 26?

Mr Labelle: Not to my knowledge. I don't even know of any group that was consulted or even brought in when it came to changing the labour legislation either. All the bills that we've seen this government do have been done unilaterally on its own, and hopefully it'll fly and, "We'll deal with the protest," and "We'll do this and we'll do that." "We'll always try to appease those who are upset, and it's a minority."

The CSR talks about the groups that are against the government are special-interest groups, you know: "Our political system has become captive to big special interests. It is full of people who are afraid to face the difficult issues, or even talk about them. It's full of people doing all too well as a result of the status quo."

These kinds of statements fly in the face of ordinary Ontarians, because we know that maybe the party that is in power now has special-interest groups of its own. I think the legislation that we see, as far as labour legislation, omnibus bills, all the next legislation that they're tabling, kind of reflects exactly who their special-interest groups are, and there's no doubt to most Ontarians. That's not just an insult but a very big concern.

As far as a hearing, we talk about the hearing, we have the opposition of the government to thank for that. We would never have had these hearings. You tried to blindside this legislation, you tried to blindside the people of Ontario, blindside the opposition. The first reading of the bill was when everybody was in lockup. I was watching the proceedings through the Legislature that day. I didn't understand what was going on till the next day when the press got a hold of it and got more informed, but I'll tell you what, it's made me more informed Ontarian as far as the way the Legislature works and the procedure in the House.

The Chair: Mr Ramsay.

Mr David Ramsay (Timiskaming): Michel, I'd also like to congratulate you and your wife for your presentation.

The Chair: Is this a Liberal member?

Mr Miclash: Yes. He's a Liberal.

Mr Ramsay: Okay, thank you very much.

Mr Clement: He just lost his moustache.

The Chair: Without the moustache, I didn't recognize him.

Mrs McLeod: We allow change.

The Chair: My apologies.

Mr Ramsay: Michel, you just referred to the action that took place in the House before the holidays, and why that had to take place is also reflected in Frances Lankin's motion today that we need more time. When you read through this, I'm discovering every day new things. I want to bring one to your attention and get your opinion of it, because it worries me very much.

In regard to health care and in regard to insured services, insured services can be also such services as may be prescribed are insured services only if they were provided to insured persons in prescribed age groups. So I think what I'm seeing here is the potential for starting to rationalize certain procedures for certain age groups of men, women and children. I'm just wondering what you would think of that sort of rationalization.

Mr Labelle: Again, I believe that we have a health care system that was built by the determination of people like our former generation. What happens oftentimes is this new-wave thinking that takes over that says, to be competitive, we have to be reduced to the survival of the fittest. I believe that piece of legislation is dangerous because it starts reflecting those thoughts in our laws in the way the health care system is delivered in Ontario. I don't agree with it. I believe that health care is for everybody. It should be universal, regardless of age or financial standing.

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The Chair: Thank you, Mr Labelle. Thank you, Mr Ramsay. I will never again make that mistake, just as I will never call Ms Lankin by the wrong name. Thank you for your presentation. We appreciate your interest.

POVERTY ACTION COMMITTEE

The Chair: Our next group is the Poverty Action Committee, represented by Suzette Courtemanche and Carl Warren. Good morning and welcome to our committee. You have a half-hour to use as you see fit. Any question time would begin with the government at the end. The floor is yours.

Ms Suzette Courtemanche: Thank you. I hope you can bear with us. We're new at this. We've not been around for that long.

The reforms contained within Bill 26 are not the product of a natural democratic process, nor are they the result of evolving trends in the medical profession—that for years doctors, patients, hospital administrators and ministry officials have consulted with one another and agree that the government should be able to divulge medical records and allow the minister to unilaterally close hospitals. It would also be progressive to treat doctors like insubordinates within the health care system and grant absolute immunity to the government for any malpractice it may inflict upon the health care system. The outrage within the medical profession clearly demonstrates that this is not the case.

The proposed omnibus bill does not stem from the input of either the practitioners or the consumers of medicare. In reality, Bill 26 is a correlate to the ideology set forth in the Common Sense Revolution and one that has underscored most of the government's actions since taking power last spring: ideological opposition to the idea of, the plight of or the situation of low-income people. Bear in mind that low-income people are more than just women on social assistance. They are unemployed parents who have seen their training programs and day care slashed. They are women and students working in the service sector who have had their right to unionize denied through Bill 7. They are first nations people who have had their community development projects and youth programs dismantled. They are abused women who have had their shelters savagely cut. And now, despite the pre- and post-election pledge to not touch health care, the Conservative Party is encoding the ideology of the Common Sense Revolution in the laws governing medicare.

The Poverty Action Committee would argue that ideology has no place in the health care system and that Bill 26 will have a disastrous impact on low-income people. If passed, Bill 26 will further centralize the decision-making process in the health care sector and weaken the voices of low-income people into the system that they entrust their lives to. Those people include seniors, the disabled and chronic care patients. Bill 26 is a crude attack on these people who are not just disadvantaged due to economic circumstances but also because they are physically less able to speak for themselves. The government has clearly exploited this power dynamic in order to grant itself much of the authority outlined in section 6 of the new hospital act. Section 6 gives the minister the power to close or amalgamate hospitals. Already there is a lack of communication between the patients and those creating policies and writing directives that will affect their lives.

Last fall, at an in camera meeting, the Timmins and District Hospital health board voted to close South Porcupine continuing care facility and move patients to the Timmins and District Hospital. Patients were not consulted and discovered through a leak that their facility was closing. Sections 5 and 6 will exacerbate the kind of elitism which already exists by giving the minister even more direct influence, therefore reducing grass-roots input into how the system should operate.

Mr Carl Warren: The omnibus bill drastically thwarts the principle of medical need as one of the underlying principles behind hospital funding and supplants it with the minister's discretion. The new sections 5 and 6 no longer require that the minister fund hospitals in accordance with regulations and gives him the power to suspend, reduce or eliminate funding to a hospital altogether. It allows him to set the terms and conditions for repayment. It redefines the term "financial aid" and once again injects the minister's own ideology into this principle.

Although the term "public interest" is flaunted throughout the document and is intended to reassure us, it is empty without the process of consultation and regulation which existed in the former legislation and which will be removed in the new legislation. Even in section 9.1, where the bill defines the four elements of public interest, its tenets may be superseded by "any matter" the minister considers "relevant." The legislation is also a gross violation of people's privacy by allowing the government to divulge medical records.

Furthermore, the legislation has granted the government absolute immunity from liability in sections 9.1 and 13. These sections indicate to me the minister's and the Premier's willingness to act upon the power granted to them by sections 5 and 6. In doing so, the government has already predicted some of the damage that it is going to inflict on the health care system. If the government does close hospitals and reduce services, it will create a more two-tiered health care system in Ontario, which already exists pretty much in the north. Low-income earners will have to rely on local services and wait longer for treatment as waiting lists grow. Middle and upper-income earners can choose to dodge waiting lists and fly to any clinic or any hospital or see any specialist anywhere in Ontario, or check into an expensive American clinic.

The proposed changes to the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act will have a major impact on three groups of vulnerable low-income people: seniors, the mentally and physically challenged, children and people on social assistance. Changes to the drug laws which introduce copayments on prescription drugs do not take into account the fact that many of these people rely on multiple drugs, sometimes up to 10 or 12.

While the government has downplayed the cost of individual prescriptions for low-income people, it ignores the compound expense of multiple prescriptions for a family living below or straddling the poverty line. As the government knows, because it has already cut back social assistance dramatically, some recipients are already suffering due to these cuts and they will be forced into the awkward situation of having to choose between

medicating or feeding their families. Some may forgo doctors' visits or misuse prescriptions and make them last longer. The problem will get even worse if low-income people are forced to make up the difference between generic and name-brand drugs or bear the cost of an exorbitant pharmacist's markup.

Despite the fact that the government has reassured Ontarians that deregulated drug prices will not result in drug price increases and may actually result in a reduction, the profit motive will certainly drive prescription prices up. Again, this provision has little to do with providing the best, the most progressive and affordable treatment for Ontario's citizens and has all to do with the government's prevailing ideology, which is the Common Sense Revolution and complete disrespect for low-income people.

In conclusion, although the focus of this presentation has mainly been on how Bill 26 might affect low-income people, this legislation must be viewed as an affront to universal health care which benefits all Ontarians, poor or rich. If the government attacks our health care system, it is jeopardizing the productivity of its citizens. The Poverty Action Committee strongly urges the Conservative government to repeal this regressive legislation and build upon the accomplishments of the past, instead of creating more inequities and more social havoc in the present.

The Chair: Thank you. We have about six minutes per party for questions, beginning with the government.

Mrs Janet Ecker (Durham West): I'd like to thank you very much for your excellent presentation and for coming today to participate in this. We've found the input that we've received from many of the groups to be very helpful and very useful as we go into detailed analysis of the legislation.

A couple of points I'd like to get on the record, both in response to some of your comments and some comments that were made just previously. In regard to regulation-making powers about different classes of age, if you will, there has been no change. The Health Insurance Act as previously written had that regulation-making power. There has been no change there.

The other point is that, on the hearings, the government had been quite prepared to have public hearings before Christmas, but with the deal that was negotiated with the opposition, we basically split. So we've got half before and half afterwards in terms of public hearings to give people more time to prepare.

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The other thing is that the northern health report which has been quoted also had a great litany of the problems with the health care system in the north. We had consulted quite extensively, and there are many comments about medical professionals concerned that the fee-for-service system, as it exists under previous government-OMA agreements, was not meeting their needs. We've all heard about the problems in Red Lake. That's one of the reasons why the government has decided to move on the recommendations of the Scott commission to help try and solve some of those problems in underserved areas.

Also, the underserved area program itself wasn't working. The problem in fact has been getting worse, which is why the minister has brought in steps in this

legislation to try and fix those problems but has also given the medical profession additional time to say if there are solutions out there that a government hasn't tried in the last 15 years. None of them have worked, but if there are new ones, let's talk about them.

The other point is that we agree that local input for changes in the health care system is very important. That's why what this bill does is allow the power of the minister to implement the recommendations of the district health councils, who quite appropriately will be making the planning recommendations to the government, as they have done and are doing in many regions of the province.

Finally, this legislation does not give the minister the power to run around willy-nilly dropping patients' records in public. It expands the current information used to manage the system. There are confidentiality protections in place, and we are meeting and discussing with the privacy commissioner. If they need to be improved or tightened, we're certainly prepared to do that.

About the copayment, the drug situation that you have talked about, one of the things that we have been trying to do is to protect the ability of the government to pay for the full cost of the drug. As you know, many people, if they're on an employer drug plan, for example, or do not qualify for drug benefits, have no way to pick up their drug costs. What we've been trying to do is to make sure that for those who qualify for drug benefits in Trillium, we can afford to do that. My colleague Ms Johns mentioned the expansion of the drug costs in the last couple of years, so many provinces have gone into copayment mechanisms, as we have.

With those savings, what we've been trying to do is also to extend drug benefit protection through the Trillium for 140,000 additional people who didn't qualify for drug benefits, so we've been able to do that. How would you suggest that we protect the drug plan, protect the ability of people to have the full cost of the drug paid, be able to extend it to further people who've needed that support and also be able to bring on new drugs, more expensive drugs which previous governments have had difficulty getting on the system? How would you propose that we are able to do that if we don't start changing the system and follow the copayment mechanism which many other provinces have done?

Mr Warren: I don't deny that there are certain elements in the health care system that have to be reformed and that were addressed in the omnibus bill. I think it's quite plain that there are very contentious aspects of it, like the powers that the minister is given, the centralizing power, unilaterally closing hospitals. Those kinds of things are very contentious, obviously, and basically those are some of the things that we're addressing today.

In terms of copayments, I understand that other provinces do other things. They may be draconian, but I don't think that Ontario should be following the same example. I don't think that just because they are doing that necessarily means that we should feel as though we should be doing the same things.

I'm not too familiar with all of the aspects of Trillium and how that works. I don't believe that copayments are a good idea, for the same reason I have mentioned

before, that many families have multiple prescriptions and the expense compounded with several can be a lot to bear for a family on social assistance or for a senior or for people who are living below the poverty line. I would suggest that it is the government's responsibility to come up with more constructive alternatives than slapping user fees on people who are living below the poverty line.

Mrs McLeod: I do have a couple of questions, but if you'll bear with me for a moment, since the government wants to use some of the time to set the record straight, I think it's important that we make sure it's set a little bit straighter.

I first want to ask the government to recognize the fact that the raising of the concern about age as a criterion in determining what is medically necessary becomes very important when you have a new provision in an act that says the cabinet, by regulation, will set out under what conditions medical services will be paid for.

Up until this act's proposal, the decision about what would be paid for as medically necessary was determined by a committee of physicians. When government is going to determine what's medically necessary and when that is clearly going to be driven by the cost concerns that the government keeps expressing, you do worry about whether we're going to get a rationing of health care based on age as a criterion.

The second part of the record I would set straight is that you're absolutely right to be concerned about the disclosure of personal information. The privacy commissioner has made it very clear that he feels the provisions of this act constitute a serious consequence for the invasion of personal privacy, and I believe this act will have to be amended in accordance with the privacy commissioner's concerns.

Last, I wouldn't in any way feel that you should be apologetic to the government about your concern about copayments. An earlier presenter to this committee this morning indicated that the experience of at least one province in introducing copayments was that the utilization went up, and therefore the cost to the government of the drug benefit plan would go up with the introduction of copayments.

Those are all very legitimate concerns to express, and that does take me to my question. I just want to ask you to expand a little, because I think you see the face of poverty in your communities, and there are many aspects you've touched on that relate to the price the poorest in our communities will pay for the changes in this act.

One of the things that worries us is the deregulation of drug prices themselves and the fact that we don't know what that's going to do to drug prices. For those who aren't on the drug benefit plan, that could mean they're facing increased prices for drugs, and in smaller communities that may be a particular problem.

One of the things the minister has suggested in the past is that people will have to barter for drugs, find where the cheapest drug is. I wonder if you might comment on whether you think the people you see in your communities who need access to a drug can go out and barter for it. And in a small community, where are they going to go to barter? How many different places can they go to find the cheapest drug?

Ms Courtemanche: I think everyone knows that accessibility here in the north is limited. Also, we've had calls coming in right now because a lot of people are worried about this, especially low-income, especially social assistance recipients. Now they want to introduce a \$2 copayment. Social assistance recipients have already been cut by 22%. They have to make up the difference, which hasn't been implemented yet.

Now, on top of being cut, they're going to have to decide whether they're going to feed their child one month or whether they're going to buy him drugs because it's a necessity in his life, which amounts to sometimes \$100 or \$200 a month. If that child needs a special drug which is not on the list of generic brands, that means they have to pay the difference.

For example, someone right now is using antibiotics for their son. This won't be on the list, as he's been told by his pharmacist, so that means he has to pay the difference of \$40 a month to get that drug because the child is allergic to all other drugs that could benefit him.

You're starting to run into a lot of problems which the government won't be able to handle on an individual basis. Some of these people are really going to be paying for those mistakes.

Mr Ramsay: Thank you for your presentation. Governments have always tried to grapple with poverty. Today, we have fewer and fewer tools, but three main ones that remain would be looking at the income tax system so you could take low-income people off the tax rolls so they could at least retain the money they are earning. That's something I think we need to be pursuing, and I would say to this government that if you are to bring in a tax cut, that's where you should be bringing in the tax cut, to low-end people. The other is a public school system so there's universal access for everyone for education. The third is why we're here today, and that is a universally accessible health care system.

1020

It seems to me that when you look at the changes through schedule H, and you've mentioned many of them, a lot of these changes are going to impact very harshly upon low-income people. Why do you think this government is mounting this attack on people in poverty? Why do you think this is happening when over the years we've all tried to work together to alleviate this inequity as much as we can?

Mr Warren: As Suzette said at the beginning of the presentation, Bill 26 is not the result of years of consultation nor is it the end result of progress within the medical profession. It was created in a vacuum, and it's puzzling to know why we have this bill. But when you look at some of the sections and when you look behind the fine print, it's very much in keeping with the ideology of the government, which has been a total disregard for low-income people.

We've seen that in terms of cuts to low-income people, their day care and their training programs. First nations people in the city of Timmins, who are low-income people, have seen their youth programs obliterated and dismantled. The Timmins Native Friendship Centre has been cut to the bone; they've had to lay off several people. Of course, directly with this, low-income seniors,

the physically and mentally challenged, all these low-income people, are being targeted through this legislation.

By encoding this ideology into the health care system and allowing themselves to close hospitals and do things unilaterally, they're giving themselves the leverage to give the richest citizens in Ontario a tax break.

Ms Lankin: I want to take a moment to put a couple of things on the record in response to Ms Ecker's comments, and then I'll turn it over to Mr Wood, who has a specific question for you.

One of the things that has angered me the most going through this process are the myths and the misinformation that the government puts out with respect to what's in this bill. Ms Ecker said to you very specifically, in response to your concern about the provision of services to prescribed age groups, that that was in the old bill, that nothing's changed, that there was always that power and nothing's changed. Let me tell you what has changed, because she is absolutely wrong and that is not correct information that she's given you.

In the old bill, under the regulation-making section, section 45, there was a similar provision, but there was a proviso at the end of that section that said, "no service or age group shall be prescribed under this clause that would disqualify the province of Ontario under the Canada Health Act," a very specific reference, and it goes on to talk about consideration by the government of Canada because the plan would no longer satisfy the criteria under the Canada Health Act. You have a protection there in the old legislation that these provisions must be done in accordance with the Canada Health Act.

That particular clause about prescribing by age group has been plucked out of that section with the protection of the Canada Health Act and has been put in another section of the legislation with no reference at all to the Canada Health Act.

Anyone who looks at legislation, if you ever had a case on this and went before a judge of some sort, has to interpret: What was the intent of the Legislature? Why would they move it away from the protection of the Canada Health Act and put it without the protection of the Canada Health Act? It has to be somehow different, or why would they have made the amendment?

The government has never answered the question why they are moving that section. The only difference, and it's a big one, is that it's taken out of the protection of the Canada Health Act. When she says to you, "There's no difference," she's not telling you the complete story. I find that very upsetting, and we went through this on a number of occasions in the first week of hearings.

Privacy: She said to you, "There's no difference between the old act and the new act." Why are they making amendments, then? And why did the privacy commissioner, who is the person most knowledgeable about these issues in the province of Ontario, come before us and present us with pages of amendments that he said were necessary to protect private information, health records? He said the government's amendments from three various sections, the multiple acts that are amended, when put together constitute a grave breach of privacy. Again she said: "There are no changes. There's

no problem." The privacy commissioner says no, and when you read the words you can see that's not true.

In terms of the excuses they use, on copayments, for example, it's that every other province has copayments so we should have them too. Well, they're also deregulating drug prices. You know what? Every other province regulates drug prices. It's okay for Ontario to deregulate there and do something different, yet that's the excuse they use for copayments.

You don't get the whole story when you listen to those comments. I just wanted to get that on the record and assure you that the points you raise are very valid.

Mr Len Wood: Thank you for coming forward with your excellent presentation on the poverty groups. As you're probably aware, I have a lot of first nations, aboriginal people within my riding and lot of poor and low-income people. Even this bill's title says "promote economic prosperity" and "streamlining and efficiency."

Throughout your presentation, what you're telling me is that it seems to be an attack on the low-wage earners, the people who are living below the poverty line. What would a family with a couple of children, even if they're just on minimum wage, who don't have money to pay a \$2 prescription fee—let's say there is a number of prescriptions; that they have pneumonia or this and that. It's going to mean an awful drain on the hospital system. Where a simple prescription was being fully covered before, now they're going to end up hospitalized as a result of the parents or parent not having the money to pay prescriptions, whether it be in the aboriginal communities or people on social assistance or welfare, as a direct result of the 20% they've already cut. Now they're being penalized again in order to give a 30% or a \$6-billion tax break to the wealthiest people in this province. I just want to get your comment on that.

Ms Courtemanche: First of all, I'm not aware of everything that's being done with Bill 26, but there is one thing I know for sure in looking at everything that's been going on since last August, and that's the fact that, yes, people are saying they will be getting a tax break. I can't see that tax break coming through in the first place, because if we're getting it back at the top, we're going to be paying it at the bottom somewhere along the way.

Furthermore, the ministry keeps saying they're cutting everywhere and there are going to be jobs available to people. In December, we sent out letters to the businesses here in Timmins, non-profit and profit, asking businesses to please hire people who were on social assistance so they could make up the differences of their cheques. We didn't get one response, not a single response.

If the government is saying there are jobs out there, I wish they could produce them because I've got a lot of low-income people right now who are asking me for jobs—not that they want to be on social assistance, either. They just want to get off, but there are no jobs out there for them. If there were jobs and they could be earning some kind of money, they could pay for their drugs.

The Chair: Thank you. We appreciate your attendance here this morning and your involvement in our process. Have a good day.

Ms Lankin: Mr Chair, while we are exchanging groups, could I place a question on the record for the

ministry? It's with respect to the amendments to the Health Insurance Act, specifically subsection 18.2(2). Section 18.2 is the provision in which the general manager now gets to make a decision to refuse a payment to a physician or any other health care practitioner, and subsection (2) is if the general manager has reasonable grounds to believe that all or part of the services were not medically or therapeutically necessary.

I asked a question with respect to that in the first week of hearings and the response that has been tabled by the ministry indicates that two sections of the previous act have been amalgamated, which I think we as a committee discovered during that first week. But they say specifically that the therapeutic necessity which is included is in reference to the services of practitioners and health facilities, while the reference to medical necessity is included with reference to physicians' services.

I would like to ask the ministry, particularly the ministry lawyers, for an interpretation. As I see it, it simply says the general manager can apply these tests and they are all included. There's no reference, no way of insisting that medical necessity be applied as the only test to physicians' services. So my question: Is it not the case that the bureaucrat applying this test will have, necessarily by the legislation, the opportunity to apply a test of therapeutic necessity and medical necessity to any doctor or health facility or practitioner and that in fact there's nothing in the legislation that structures it, that says one test is applied to one group and one test is applied to the other? I think in a sense that might be sloppy drafting in the way in which that has been put together, and that gives me concerns.

1030

The other question I have is, in reading the old bill, there is no definition of "medical necessity" or "therapeutic necessity." In the past, under the old legislation, it was a Medical Review Committee, which was a doctor's peers, and it was a peer committee of health practitioners for the particular profession involved that would apply those tests of medical necessity or therapeutic necessity. Now it is a bureaucrat in the Ministry of Health who will do it, who is not a professional in these fields. I would like to ask the question, what test are they going to apply, what definition are they going to use and how they are they going to make that judgement, given that it is not any longer a peer review group?

The Chair: Does the ministry staff have the question sufficiently? Okay.

CANADIAN MENTAL HEALTH ASSOCIATION, TIMMINS BRANCH

The Chair: Our next group is the Timmins branch of the Canadian Mental Health Association, represented by Judy Shanks, executive director, and Catherine Yard. Welcome to our committee. You have half an hour to use as you see fit. Questions would begin with the Liberal Party. The floor is yours.

Ms Catherine Yard: Good morning, Mr Chair and fellow committee members. I am the president of the local mental health association board of directors, and Judy Shanks is the executive director of the agency.

The Canadian Mental Health Association, Timmins branch, appreciates the opportunity to present a response regarding Bill 26. The CMHA, Timmins branch, is involved in health care in the province of Ontario and in particular in mental health and family violence. We appreciate the opportunity to express our views on the future of health care in the province and, in particular, northern Ontario, which we see as a major difference in the province.

Recently, our Canadian Mental Health Association provincial office made a presentation to your committee in Toronto. In order not to be repetitive, we would simply like to emphasize that we support that presentation. However, we do feel that it is imperative to add a northern perspective which more specifically reflects the issues of the north and in particular the Timmins branch views.

The Canadian Mental Health Association, Timmins branch, is an incorporated, registered, non-profit organization chartered since 1962; 100 volunteers are active in direct board and committee service in the Timmins district. CMHA, Timmins, is one of 36 branches of the Canadian Mental Health Association, Ontario division. The branch is a strong advocate for the rights of adults and children with mental health difficulties, as well as for women and children and victims of family violence.

Timmins branch programs are funded through government transfer payments—in the amounts of 56% from the Ministry of Health, 34% from the Ministry of Community and Social Services and 6% from the Ministry of Housing—the local United Way and supplementary funding activities.

Ontario's current economic environment is burdened with a high budget deficit, mounting public debt and continually accumulating interest. CMHA acknowledges this environment and understands the government's need to act to reduce the debt and the interest we pay on it as an important measure of fiscal responsibility in order to create a better future for growth and opportunity in this province. The CMHA, Timmins branch, acknowledges the necessity for the government to act and to act quickly.

We do not wish to portray the message that we are in disagreement with the government of the day, but there are certainly various changes we hope can be instituted in the north to ensure that northerners are adequately provided for.

The distribution of mental health services is fraught with inequities. We realize that the government must take a stand to adjust these inequities but must keep in mind the northern uniqueness. The north covers a large geographic area, sparsely populated except for a few urban areas.

We have always had difficulty in the recruitment and retention of mental health staff such as psychiatrists, psychologists, social workers etc. More than ever, we are once again at a critical stage in the recruitment and retention of professional staff in northern Ontario and attempting to overcome the problem. The government must look at various options such as a regional approach to the mental health care delivery system, utilizing existing dollars and human resources in a much more effective way than is presently being done.

Prior to enacting legislation, the government should look into the following areas:

(1) The distribution of psychiatrists, psychologists, physicians and social workers. Fair and equitable criteria for balancing the distribution of mental health care professionals in Ontario should be developed, particularly in the north, where we are very underserved.

(2) Incentives and improvement in working conditions, differential remuneration, brief stay etc for professionals who work in areas which are historically faced with low supply should be considered. For example, in the north, a strong mental health support system would support psychiatrists and physicians and aid in their recruitment and retention.

The Minister of Health and his deputy minister and ADMs had a number of meetings with a variety of groups and individuals prior to the release of the fiscal and economic statement. In some of these presentations and discussions, several messages were being brought forward. At this time, I would like to highlight a few points that were brought forward.

(1) The Ministry of Health is reviewing the business it is in and does not intend to be in direct care in the future. CMHA, Timmins branch, is in agreement with this and would like to be one of the key service providers.

(2) The ministry lacks an adequate data and information base upon which to make the best decisions. CMHA would be willing to take a lead role to assist in developing an information system.

(3) The ministry is determined to have restructuring in health care occur to provide a better continuum of care. CMHA feels we could assist in this planning. One suggestion that we hope would be given consideration is looking at the delivery of mental health services in the north in a regionalized delivery model.

(4) The budget will include the largest reductions ever in Ontario government spending. Redistribution of dollars may be one of the best cost-saving measures.

(5) The ministry is considering reviewing all of its agencies, boards and commissions with a view to having fewer of them. CMHA believes that the end result would be a better utilization of volunteer time on boards and committees if such a move was enacted.

(6) The government has indicated that the information systems will be dramatically improved. We applaud this comment; however, we hope that action, and not more consultation, will be the end result.

We believe that in the mental health field this cascading process, if handled properly, will likely see the current \$1.5-billion system need little or no more funding to cause it to operate more effectively for the consumers of services, not to mention the staff and volunteers involved with them. The approximately \$385 per day cost to care for individuals in provincial psychiatric hospitals can be much better utilized in many instances either to retain individuals near their homes or to return them to their community at a much more rapid rate. Outfitting the general hospital psychiatric units to provide emergency backup when cyclical crises occur will be fundamental to permitting this change to happen.

In the community agency component of the mental health and addiction fields, the great proliferation of

small agencies begs to be part of an organizational solution. Fortunately, the multiservice agency model does not appear to be in favour with this government for the long-term care field, so presumably it will not be found acceptable in the mental health field either. However, we need a structure which will allow funders to deal with community agencies in an efficient and effective manner in terms of initial funding; as well, concerning accountability/evaluation, it will require some sort of massification, or organized approach to pooling resources.

The creation of mental health and addictions network organizations could be the best transitional solution for the mental health field in the north. In the Timmins area, for example, very large as we are, a mental health services network organization linked to a district health council or a similar planning body or group from a policy planning/definition of service perspective and linked to their funders for financial support would be a definite asset. The funder, of necessity, would set general parameters for the services they want to see provided with these funds. In this model, the network organization would be responsible to ensure evaluation of service quality and outcomes. This model would place the mental health network organization in a position to secure services needed by consumers from any entity in the spectrum of available services. The model would be client-centred, holistic and based upon the psychosocial rehabilitation approach and not fragmented.

1040

It is well known that systems, as they grow and develop powerful entities within, can easily become self-absorbed and lose sight of the central purpose for their existence. We need strong leadership in the various elements within the system, but at the same time there must be mechanisms in place to balance those strengths. We encourage members of this committee, as you examine Bill 26, to ensure that the processes are in place to provide balance and to ensure a consumer focus, which we must not forget.

The current model with Queen's Park as the government core causes loss of time and inefficiencies. A regional-based model would recognize the specific needs for a particular area.

The district health council areas could assist in defining the administrative and geographic size of any particular mental health services network.

Reduction of services is not the answer. We need to look at the redistribution of dollars that are already in the system. It is important that we look at delivery of health care services in the north much differently from those in the south and the larger areas.

In the past few years, a number of health programs have been implemented on a regional basis in the northeast. In 1985, cancer became regionalized; 1989, dialysis; and in 1993, diabetes. Regional programs have proven to be cost-effective when you are dealing with a sparse population scattered over a large geographic area with limited resources.

In discussions with my Canadian mental health colleagues throughout the northeast—Timmins, Sudbury, North Bay, Sault Ste Marie and Kirkland Lake—there appears to be a genuine interest in pursuing this concept

further. For example, we have had some serious discussions around a generic community support worker. This concept would not only serve the psychiatric population, but as well could be utilized to work with brain injury, developmentally challenged, dual diagnosis, concurrent disorders and forensic groups.

The philosophy and training for the generic community support worker is based on the psychosocial rehabilitation model. This model refers to a client-centred approach to working with the disabled population, seniors and youth. It can be adapted to cross over with all ministries and is in fact already present within the approaches utilized by services funded by various ministries. Some of the target populations already using this type of approach are those from the Cochrane-Timiskaming Resource Centre, Community Living Timmins, South Cochrane Addictions Services, Adult and Family Services-Northern College of Applied Arts and Technology, and the Timmins and District Hospital.

In the north we feel that the services should be very comprehensive, consistent, coordinated and cost-effective. You may ask, how do we come up with cost-effectiveness? If each agency is trained under one model, then whether you are a community worker or an institutional worker, people would have the same goals and the best interests in mind to work with the client or consumer. This would also make the transfer of institutional worker to community worker quite smooth and effective.

All levels of government need to work in a collaborative and cooperative manner. For example, in the Timmins area a group of approximately 25 local agencies has formed the Timmins Health and Social Service Coalition. Currently, the group is meeting to share information about support services and to develop short-term opportunities for collaboration. Examples of common support services are: (a) purchasing of equipment and supplies, photocopying etc; (b) group employee benefits—employee assistance programs, human resources, health and safety; (c) information systems, education and training; and (d) public relations and information dissemination to the public. The group is also looking at opportunities for creating additional revenue.

We ask that you review our response carefully. The Canadian Mental Health Association, Timmins branch, feels that with changes brought about through co-operation and collaboration and reflecting a northern perspective, we would support the government's actions in this section of Bill 26. We ask that you take time to consider the uniqueness of the north and consider the concept of regionalization. If we all work together with the common interest of our consumers and clients in mind, the battle can be won. Thank you.

The Chair: Thank you. We've got about four minutes per party left for questions, beginning with the Liberals.

Mrs McLeod: I appreciate the fact that you wanted to bring a northern perspective to the presentation. I think that's going to be important to our committee as we travel across northern Ontario. I do want to just touch base, though, because you've indicated your support for the presentation that the Canadian Mental Health Association had already made. One of their very real concerns was about the increased access to patients' medical

records. This was a particular concern for patients with psychiatric records in a doctor's office. I assume that in supporting that presentation, you share that concern.

The other concern, and I appreciate your comments on it, is with the whole aspect of copayments for people who have a psychiatric disability—and obviously not all people who are facing some mental health challenges would be psychiatrically disabled and therefore be facing a copayment; others would have to pay the full cost of their drugs—those who are on a disabled pension. The cost of the copayment and the fact that there's a concern that with psychiatric patients often they're not only on four or five prescriptions, but they get very small amounts and have to have it renewed repeatedly—the cost of the \$2 copayment might not seem like a lot, but it could be punitive for psychiatric patients. Do you have any further comment on that?

Ms Yard: One of the areas that I touched on briefly was the community support worker program that we are involved in and would like to increase our involvement in, and that certainly would assist our clients in formulating a more effective plan for their life in terms of assisting them with budgeting and that kind of thing. Part of their role is to consider the entire entity of our consumer group and look at how we can—we certainly don't agree with the \$2 copayment, but if we need to look at assisting our clients in dealing with that copayment, then we will certainly do that.

Mrs McLeod: Yes, that's right. There's a lot of community support needed in terms of management, lifestyle, housing, which leads me to my next question, which is: In the consultations that you mentioned the government had prior to the release of the fiscal and economic statement, are you aware of any commitment that the government has made that any dollars saved in health care would come back into the northern Ontario communities?

Ms Judy Shanks: We haven't heard that directly from them, but it's certainly an argument that we continue to hammer away at. We hope that consideration would be given, and I think that's the way it's been left with us in any of our discussions or dealings with the respective ministries.

Mrs McLeod: I would urge you to continue to hammer away at that, because one of our very real concerns is that with the size of the cuts in health care that the government has to realize over the next little while to meet the Finance minister's bottom line, the dollars that are saved, if in fact there are any savings through the components of Bill 26, are going to be lost to communities, certainly in the immediate term.

Ms Shanks: I guess one of the frustrations for us in the mental health field is that over the last number of years we've talked about the restructuring of mental health in particular and looking at the psych hospitals, and there doesn't seem to be any real, significant movement in that area. When you look at, for example, our local psychiatric hospital, North Bay Psychiatric, which 10 or 12 years ago was operating on a \$34.5-million budget with almost 900 patients, they have less than 250 patients and they're still operating at \$34.5 million, and there's been no movement. So I guess that's one of the

things that we still argue. And it's not just our psych; I think it's psychiatric hospitals across the board.

1050

Mr Bisson: I've listened quite intently to your presentation, because as people here might know or may not know, I was part of that coalition and did a lot of work with Judy and yourself in regard to a lot of the issues you talk about.

I guess I'm a little bit puzzled, listening to the presentation—and I don't mean to be argumentative here—but where do you see, in Bill 26, regional planning being enhanced through the bill? Just to put it in perspective, because I agree with you: We need to have more regional planning, not less of it, and when you say that you're in favour of Bill 26 because it promotes regional planning when it comes to not only mental health but our health care system overall, where in the bill does it allude to that? I've read it and I haven't seen that.

Ms Shanks: I don't think we were wanting to be as specific as that, Gilles. I think what we were saying is that we have to look at issues differently in the north.

Mr Bisson: Yes, completely.

Ms Shanks: Certainly, by being able to give a solution to the problem, hopefully in looking at Bill 26, consideration to some of the solutions and not just antagonizing the problem further may assist us in moving towards that direction.

Mr Bisson: But is there anything specifically in the bill that would allow that to happen?

Ms Shanks: I'm not convinced that there is, but at the same time I haven't read—it certainly wasn't a short time frame. If you look at the presentation done by our provincial office, I think they alluded to some of those areas. That's why I'm saying we certainly agree with that. What we're trying to do is get a northern perspective to reinforce where we see that some of the solutions are and not just create more problems.

Mr Bisson: I wanted to make sure I understood your position. I didn't want to see it changed, because I always agreed with it.

The other thing is that you make the comment, on page 6 of your submission, that we need strong leadership, but you need a mechanism to balance off those strengths. Are you talking about strong local leadership or strong central leadership, just to be specific?

Ms Shanks: I guess, again, I'll challenge you by saying that in the north, for example when we have had any kinds of supports, its always been from Toronto that we have to get a program supervisor or whatever. We're saying if we could decentralize that and make it local—by the time I get an answer back from Queen's Park, I've already done the deed and taken my chances that it's going to work for the best, and to this point it has.

Mr Bisson: So you still support regional planning as a concept?

Ms Shanks: Absolutely.

Mr Bisson: Do you see this bill enhancing regional planning?

Ms Shanks: Let me clarify something. I don't support regional planning for the entire province. I'm saying that I think in the north we have been trying to cry out for a number of years to say that we are unique, and I would

still argue that our uniqueness is created because of the geographics, because of the limited resources, because of the difficulties. And we've tried how many different ways to look at recruitment and retention of individuals? But I think once and for all we've got some leaders within the north that—if we can have the opportunity to bring those people forward in order to develop and work on their own, with some guidance but also some direction from the ministry so that we're not being pulled back by Queen's Park to say, "Well, this is the way we do it in Toronto, so therefore you have to follow the lead from Toronto."

Mrs Johns: I'd like to thank you for being here and for your presentation today. We appreciate all the help we're getting from many organizations. I just want to thank you for recognizing that the bill is about trying to look at the best ways to provide health care services, and that redistribution may have to take place to allow us to get the best health care system that we can in the future.

I want to comment just for a minute on the fact that the intent of the bill relating to your parent or umbrella firm was that privacy and confidentiality of health records were never to be, willy-nilly, allowed out to the public, so we will be making amendments that will close that down. It wasn't our intent to do that. We felt we were providing a bill, but if there's public concern about it, we'll do something about that.

We are putting money back into the health care system, and I want you to know that. As you know from some of the things I've been doing, there is money going back into long-term care, for example. We have been making investments in dialysis; we're talking about long-term care; we're talking about a number of areas that we will be reinvesting in. I don't think your assumption is incorrect that there will be money that will be allocated to different areas of health care as we find the community need. We believe we have to find the savings first and then reallocate, so it's a little different than has happened in the past, but we believe that's the way it has to happen.

I was interested in your comments about the psychiatric hospital and the dollars in North Bay. Why would so much of the service be taken away, so many people be taken away and not dollars taken to follow into the community at the same time or to follow the people who were being helped somewhere else? Do you have any ideas about that or comments about how that system evolved, why dollars didn't move or why they weren't taken back into the public purse or back to the taxpayers if they weren't being utilized?

Ms Shanks: It was our understanding over the previous governments, going back even to all three previous governments, that eventually that was to happen. I've been in the mental health field for 20-some years and it hasn't happened. I hope we would certainly work towards that, but I think we've consulted this whole process time and time again. I've got documents in my office about this high as to how many times we've got consultation on it and I think the plan is there. Putting People First, the last document around mental health reform, is certainly the one that I hope continues on, because it's a 10-year document and we're in our fourth

year of planning for that. It specifically states how institution dollars would be sent back to communities or moved in that direction. Why it hasn't happened I'm not sure, but at the same time I'm hoping we can advocate to make sure it does happen.

Mrs Johns: The doctors' distribution, as you talk about psychiatrists and not being able to get doctors in the north: Given that you have 20 years of experience, is the problem getting worse? Better?

Ms Shanks: The problem's getting worse, and I don't want to speak for the doctors, but one of the things we have at hand now that can resolve some of this, for example, especially in the psychiatric area, is to look at the whole issue of video-conferencing. We can't get the doctors. There are 15 doctors, psychiatrists, sitting in North Bay and it's four hours away. Somehow that highway only goes one way and it's not coming back up north. What we're hoping for is that the technology that's coming into place—if dollars were allocated to these kinds of resources, possibly that would assist in keeping some individuals here, or at least getting some individuals here with the various professional disciplines.

If we are able to look at utilizing all of our resources, but I'm saying there may be some initial dollar input to start with, to kick the system into start, then we can certainly look at how we can keep doctors. Isolation certainly is a big factor here, and if you don't have anyone to consult with, then it really does become a little bit mind-boggling, to say the least, and quite lonely when it comes to trying to make some decisions.

That's why we're talking about the regional model; that's why we're talking about networking. With those people who are staying, the front-line workers who are staying, if we can utilize some of the training and support of dollars to make sure that video-conferencing is going to be a reality for us and financially available, then we hope we can maintain some kind of system on a long-term basis.

The Chair: We appreciate your attendance this morning and your interest in our process. Thank you.

The next group is Local 1140 of the Canadian Union of Public Employees.

Mrs McLeod: Mr Chair, while they're coming forward, could I also table a question for the ministry staff? It's a follow-up to the question Ms Lankin asked, and the response was tabled today, on the way in which the copayments for the drug benefit program would be implemented. I'm concerned, quite frankly, in the ministry's response, that there will be no implementation plan in place until June 1.

If there's to be a cost saving for this measure, there has to be some indication of what the cost of putting the program in place will be. I would like at least an estimate at this point of what the cost of the billing will be for administering the copayment. It's apparent from the answer that it will be a retroactive billing that is put in place since the decision about whether to charge or not charge can only be made after the claim has been filed. I'd like there be some estimate of the cost of this system.

1100

The Chair: Is the question understood? Thank you.

CANADIAN UNION OF PUBLIC EMPLOYEES LOCAL 1140

The Chair: Good morning, and welcome to our committee. We appreciate your attendance here. You've got half an hour to use as you see fit. Questions would begin with the NDP party. If you'd identify yourself for the record, we'd appreciate it. The floor is yours.

Ms Brenda Cooper: Good morning. My name is Brenda Cooper. I've been employed in the health care field for the past seven years, and as a public worker I'm very concerned about the effects of Bill 26.

The majority of changes that will affect hospitals and the delivery of institutional services are contained in schedule F, Health Services Restructuring. This portion of the bill gives the Minister of Health unlimited authority to enact the onerous cutbacks announced in the government's economic statement. The elimination of funding to the hospital sector could result in the layoff of up to 26,000 workers and will severely restrict access to health care services.

Bill 26 will surely accelerate the decline in the quality of care that has occurred as the result of years of under-funding to the hospital system. In addition, it will profoundly damage publicly funded medicare and encourage the privatization and corporatization of health care. It is an attack on the elderly, the poor and all those who are most in need of compassionate, high-quality care. If this legislation is enacted, we will see rapid encroachment by the private sector, whose primary objective is to capitalize on illness and disability.

A key goal of the government, reflected in the legislation, is the realignment and rationalization of hospital services in Ontario. One mechanism for this restructuring will be the creation of the Health Services Restructuring Commission. This group will be appointed by order in council and can be assigned duties by regulation, under terms and conditions determined by cabinet. The minister could delegate his authority to the council, which will be empowered to carry out restructuring in whatever he deems appropriate.

Schedule F will give the minister virtually unlimited powers with respect to funding, operation, closure and amalgamation of public hospitals. Like many other portions of the bill, these provisions represent a fundamental change to the relationship between public institutions and government. It allows the minister to ignore the needs of the local communities who access hospital services, and gives him unlimited control over all hospital matters.

The minister will be able to reduce, suspend or terminate hospital funding at will if he deems his decision to be in the public interest. Currently in the Public Hospitals Act, funding is allocated by specific criteria and regulation. The minister cannot terminate funding simply for budgetary reasons; his decisions must take into account their effect on patient care. Under Bill 26, the minister can select the criteria he regards as relevant when making funding decisions, including, specifically, the availability of financial resources.

The minister also has the unlimited authority to close hospitals, force mergers between institutions or order hospitals to change or eliminate the types of service they

deliver. An acute-care hospital may be directed to eliminate all its chronic-care beds or shut its emergency room. Since the government has made it clear that too much money is spent on inpatient services already, it can also use this bill to compel hospitals to contract the volume of acute care they provide. This will result in patients being forced out of the system much too quickly or even denied appropriate types of care when needed.

Since the government has also stated that up to 38 hospitals in Ontario must be closed, the legislation has provided it with the necessary mechanism to achieve this goal quickly and aggressively. No public consultation will be necessary even on a superficial basis.

Rural Ontarians will be particularly hard hit by closures. As small local hospitals are shut down, users will be forced to travel greater distances to access even the most basic services.

As well, the minister will be given the power to make "any other direction related to a hospital that the minister considers in the public interest." This potentially has the effect of giving the minister the power to dictate virtually any aspect of the operation of hospitals.

The bill will also provide sweeping powers to the minister to appoint a hospital supervisor whenever he deems it appropriate. If a hospital board were to resist a restructuring direction from the minister, he could appoint a supervisor who would have the exclusive right to exercise all the powers of the hospital board. Community control of hospital services would be completely taken over by a supervisor who is required to follow any direction issued by the minister with respect to hospital operations. The bill states that the supervisor's powers are virtually unlimited.

When hospital boards do comply with the ministry directives, the bill will provide them with unrestricted power to carry out these orders, regardless of the provisions of any other legislation or the hospital's own letters patent or bylaws.

The bill also will give the minister the ability to write regulations concerning the disposal of hospital assets and capital funds in the event of merger or restructuring. Potentially, he could establish regulations that shift assets allocated or reserved for specific purposes, like foundation money, to different parts of the health care system.

Finally, the bill provides tremendous levels of liability protection to the government and to the boards of hospitals during the restructuring process. They cannot be sued or held accountable for virtually any action they take under the authority of the new legislation.

One of the aspects of Bill 26 that really concerns and upsets me deals with the loss of confidentiality of medical information. Confidentiality of personal medical information became a thing of the past under this legislation. The Harris government clearly—and mistakenly—feels that bottom-line economic considerations should override the right of citizens to have their personal medical histories held in confidence.

Schedules F and H of the bill will open the door for the minister to collect, use or disclose personal medical information for the purposes of the administration of the Independent Health Facilities Act, the Health Insurance Act and the Health Care Accessibility Act.

The act deems that every insured person under the Health Insurance Act will have authorized his or her physician or hospital or health facility to provide information to the general manager of the insurance plan. The rationale for this disclosure is that it is necessary for the "effective management of the health care system or for the delivery of health care services." Those who are most vulnerable in our society could find themselves the victims of a campaign to deprive them of adequate and necessary levels of care.

Citizens will have no recourse or protection when personal information is disclosed. The bill provides that no action can be brought against the minister, the general manager or any other member of the staff for disclosing information.

The bill provides for the minister to appoint inspectors to act under the direction of the general manager. These inspectors will have considerable powers to access and reproduce health records, books of account, correspondence and records, including payroll, employment, patient and drug records.

As if these provisions aren't cause enough for concern, the act actually opens the doors wide open for potential misuse and abuse of confidential information. Schedule H permits the minister to enter into agreements to collect, use and disclose information. We fear that these functions will be contracted out to private companies which will not be held accountable and which will be more concerned with profit-making than with the protection of the public interest through maintaining confidentiality.

We note that Ontario's Information and Privacy Commissioner has already expressed concern that the privacy of individuals will be compromised under Bill 26. We also note that the Health minister has agreed that changes would be forthcoming to ensure that the rights of the public with regard to privacy are respected. We hold the minister responsible to make such changes immediately.

Anyone who sifts through this enormous piece of legislation quickly learns that "restructuring" really means massive downsizing of the public sector.

What about the "savings" part? Obviously the government saves by cutting its spending by over \$6 billion, without even tabling a formal budget for debate in the Ontario Legislature. But what about individual Ontarians and their communities? Will the Harris government's spending cuts and the promised tax cut give us more money in our pockets?

The direction set out Bill 26 is very clear. While many of the details will not be known until regulations are in place, the bill makes it plain that Ontarians will soon pay fees and other charges for numerous services which until now have been supported out of local or provincial taxes. Even if the government is able to introduce its proposed tax cut, the saving for most Ontarians will likely be outweighed by these new charges. Inevitably, these charges will prevent many lower-income Ontarians from using services which are now universally available.

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It is difficult to predict the precise impact of many sections of Bill 26, because it will give very wide discretion to government ministers to enact regulations prescribing what other levels of government can and

cannot do. While it delegates power in some areas to hospital boards and other bodies, this is invariably matched by giving sweeping powers of regulation to provincial cabinet ministers.

By attempting to pass Bill 26 before putting these regulations in place, the government wants to write itself a blank cheque. Once passed, Bill 26 will allow government ministers to make up whatever rules they see fit without having to debate them in the Legislature.

As a member of the Canadian Union of Public Employees, I say scrap this omnibus bill which will destroy local democratic institutions, devastate public services and impose hardship on Ontarians, especially those who are most disadvantaged.

The Chair: Thank you. We've got about five minutes per party for questions, beginning with the NDP.

Ms Lankin: Thank you for your presentation. It's helpful to see this bill through the eyes of a health care worker and someone with the experience on the ground that you have.

There are a few areas you've touched on. If I were to try and wrap it all up and describe the concerns you've raised and the concerns that other groups have raised, it's that the bill centralizes bureaucratic power in a very significant way and in a sense undermines the role of volunteers.

You talked specifically about the role of supervisors in hospitals, for example, and I find that one very interesting. When the Minister of Health presented before this committee on the first day of public hearings, we asked him some questions about that. He referred to the section in the old act where a supervisor could be appointed—it had a lot of process things in front of it, but the process things had been taken out—but he said that's hardly ever been used; once or twice in the history of the act. He said: "I really believe it's an extraordinary circumstance. It's rare that it would be used, and it's not likely to be used." That really makes you question, why is he changing it, and why is he increasing the power if he doesn't think he's going to use it?

Like you said, a supervisor now can take over the day-to-day operation of a hospital. In the past, the board still ran the hospital; in major decisions, they'd have to check with the supervisor. Mr Clement, from the government, has pointed out in the past that there's really no difference. Again, if there's no difference, why are you amending it and why are you changing it? We never get any answers from them on that.

Do you have any sense of why these kinds of changes are being made? What do you expect is going to happen with those new powers the minister has taken on to himself to take over a hospital, to appoint a supervisor, to undermine the local volunteer board and to run it? Why do you think he's doing that?

Ms Cooper: First of all, I want to say that I do work in a long-term-care facility; it's not a hospital. We've already seen changes in our facility even without this bill. Our workload has become increasingly heavier. There are no more residents than there were before, so because the workload is much heavier, the type of patients we are getting are heavier.

They're not getting the quality care that they were getting before because we are doing more and more with less staff. That really concerns me because most of our residents in this long-term-care facility are the elderly, and I just wonder where we're going to go. Is it going to be less and less for this section of society?

Ms Lankin: I think you raise a very important concern that is quite general across the province in terms of what the potential for cuts to health care spending would mean. The government promised there wouldn't be cuts and they've said that any cuts they make are going to be reinvested. We'll see. I hope that's true, and we'll see on that point.

In your presentation you touched on some areas where you feel that there will be amendments necessary; one of them, for example, around the privacy area. The minister has indicated he'll consider amendments; in fact Ms Johns today said there will be amendments in this area, and we're pleased to hear that. My frustration is, given that the minister has already said there will be amendments and he has said that about a couple of other areas of the act, it would be very helpful if they were tabled.

I asked the minister that at the first day of hearings when he talked about certain amendments and I asked for a commitment that he would table them before we got on the road for these hearings. He said, "Absolutely," because he always found that frustrating when he was in opposition if the government waited until the last moment to table amendments. It seems to me if he'd table the amendments that he knows he's going to make to this health privacy area, and if they were sufficient, we wouldn't have to be talking about that today and the groups coming forward could be concentrating on other aspects of the bill.

I agree with your call for amendments and I echo your call, and I reassert my statements earlier and my plea to the government to table the amendments they know they're going to make so that the public who are coming forward in the hearings and the opposition members know, at least thus far, what their intentions are, and granted there will be more as we hear more presentations. With that, let me just say thank you very much. I assume that's the end of the time. I appreciate your presentation.

Ms Cooper: I just would like to reiterate I really feel that loss of confidentiality is an overwhelming invasion of my privacy. I feel very strongly on that.

Mr Clement: Thank you for your presentation and let me reiterate, as I have to Mrs Lankin before, that we will table amendments once we've heard from the people. We've heard from Torontonians, and that's all great, but I'd like to hear from people in Timmins and Sudbury and Thunder Bay as well. That's why I don't think any amendments have been finalized to this date in time.

There are a couple of things in your presentation where I share your concern, but I think some of your concerns are based on what I perceive to be misconceptions, and maybe reasonable people can differ on that. For instance, you've got some great concerns about disclosure. Of course, under the old act there was disclosure and there were limits to confidentiality under the old act, so we all know that. But I read to the privacy commissioner earlier the new section directed to disclosure of confidential

information which prescribed four sets of circumstances, how disclosure should take place.

Under the old act there were no limits on how disclosure should take place, so in fact the new act is more particular and more specific than the old act. The privacy commissioner had no reply to me and still hasn't given me a reply as to how my reading of the act is misinformed. I would just like to put that on the record. But if there is a way that we can amend the act, as Mrs Johns has said, to make that even more clear, I think we are quite willing to do that.

If I put it to you that way—you don't have to take my word for it; read the act and read the old act—would that allay some of your concerns on disclosure?

Ms Cooper: No.

Mr Clement: Well, I tried anyway, I guess.

Ms Cooper: Not at all.

Mr Clement: I'm telling you that the new act is more specific and more directed than the old act, and that doesn't allay any of your concerns?

Ms Cooper: No.

Mr Clement: I'm sorry we can't help you on that one, I guess.

Let me just talk then more generally about the powers of the minister. You're involved in a long-term health care facility?

Ms Cooper: Yes.

Mr Clement: You agree that your particular sector within the health care sector needs more resources?

Ms Cooper: Yes.

Mr Clement: What we're doing is allowing the minister, the publicly accountable person in this whole system to the people of Ontario, to make some decisions after listening to the district health council, after their planning reports, after their community outreach has been done, to actually make some decisions and maybe reallocate some resources so that other needy sectors within the health care sector have some more resources in their area. Would you not be in favour of that if that benefited the long-term health care sector?

Ms Cooper: I would but I don't see that happening. I have some pretty definite opinions on this whole thing.

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Mr Clement: That's fair, but if that's the net impact, if we can redirect some resources to some areas where we're not saving any money and where patients are not well served and can direct that to long-term health facilities, I think that's a win-win situation, isn't it?

Ms Cooper: Yes, it is.

Mr Clement: Gives them the power to.

Ms Cooper: But I don't see that happening. I don't see the Common Sense Revolution doing that.

Mr Clement: You're a tough person to mollify, but let me give you my assurance then in wrapping up that that certainly is our intention.

Mrs McLeod: Perhaps I can use a moment to share what I'm sure is your frustration with the comments that Mr Clement has just made on behalf of the government, because there are some ways in which we could be provided with some assurance including, I guess, the six northerners who happen to be sitting on this side of the table who would not take any offence at all if you were

to table amendments to provide assurance that you will not be invading personal medical records in the very specific way in which this act indeed sets out.

It's the specificity of what this act allows the minister and the minister-appointed inspectors to access, to remove from doctors' offices, to copy and to disclose without penalty, that very specificity is what has everybody alarmed, and I think not only the presenter today but every presenter to this committee would be reassured by the government tabling the amendments that the minister is committed apparently to tabling so that we will know it will be made much clearer that the government does not have these kinds of powers.

By the same token, I think in regard to the concerns you're expressing, you would not be reassured by the statements of the government's good intention. You've done a very thorough brief in recognizing the way in which the powers become very unilateral and very dictatorial, and I obviously share your concerns. You mention on page 2 of your brief, and I was interested to see that you recognize that one of the significant changes in this bill is that the Minister of Health is no longer even governed by regulations set by cabinet when it comes to making decisions about operations of hospitals, that he doesn't have to work within the regulations under the Public Hospitals Act.

This makes the Minister of Health, for the first time ever in the history I think of any province, able to make unilateral decisions about hospitals and to give the responsibility for making those decisions to a commission or indeed to a hospital supervisor. In the case of a hospital supervisor, there's no longer any requirement that there even be an inspector who comes in and makes a public report as to why the minister is exercising those kinds of powers. So I second wholeheartedly the concerns you're raising.

The other thing you mentioned, I think quite appropriately, was the whole question of whether or not there are going to be savings that are ever seen by individuals when there's a whole host of new fees proposed. Other sections of the bill deal with that in municipal areas, but in terms of hospitals there's not only the copayment but the possibility for additional hospital fees being charged to patients.

I wanted to ask you one specific question, realizing that you're in a long-term-care facility, one area you didn't touch on in your brief, as thorough as it was, and that's the whole question of copayment. If you haven't had a chance to look at this I'll certainly understand it. I don't know whether you work in a facility where the individuals receive a comfort allowance as sort of a spending allowance, but one of the concerns that has been raised is that a copayment for drugs, even as little as \$2 per prescription fee, would be really punitive for anybody who is in a long-term-care facility and is existing on a \$30-a-month comfort allowance. I don't know if you have any experience of that.

Ms Cooper: Some of them don't have any money left now, so that is a concern. If there's a copayment, then they can't have any of the luxuries that they do now at this facility—go get their hair done, or whatever. There

just won't be the money. There goes their quality of life in other areas.

Mrs McLeod: The other thing you point out in your brief, and I think it's an important point, is that in setting out, as this bill does, the ability of government and the minister to look at terms and conditions, one of the terms and conditions that the minister can be guided by in making decisions is the availability of financial resources. Does it seem to you that that is no longer cost-effectiveness but actual rationing of health care because of dollars, and do you see a difference between the two?

Ms Cooper: I think "cost-effective" is just a nicer word to put on it, rationalizing everything. It's cuts, whichever way you look at it, and who's going to suffer?

The Chair: Thank you for your presentation. We appreciate your interest in our process here this morning.

PORCUPINE DISTRICT MEDICAL SOCIETY

The Chair: Next is the Porcupine District Medical Society. Good morning and welcome to our committee. You have a half-hour to use as you see fit. Any time left for questions will begin with the government party. The floor is yours, sir. Please introduce yourself to us for the record.

Dr Claude Vezina: My name is Dr Claude Vezina. I'm a radiologist in Timmins, a native of Timmins, having returned here approximately a year and a half ago from Ottawa. I'm also expecting Dr Dave Huggins. I'm told he's on his way from his office, so hopefully he'll join me as I present.

I would like to thank you, Mr Chairman and committee members, for the opportunity to present on behalf of the PDMS, the Porcupine District Medical Society, and also as a radiologist who serves nine hospitals.

We are a group of four radiologists who serve the Timmins and District Hospital, but I would like you to note the geography of the hospitals that we also serve in the district. I will list them for you, since I think geographically this is probably the greatest section of patient care that you have in this province. In addition to Timmins, we serve the hospitals in the communities of Hearst, Kapuskasing, Smooth Rock Falls, Cochrane, Ansonville, Matheson, Kirkland Lake and Englehart. Those are a lot of miles, and in the weather of today, very dangerous miles.

In this presentation, which I will try to keep as brief as I can, I will try to wear these different hats in delivering my thoughts.

The Porcupine District Medical Society fully agrees that changes are required to solve the local and district drastic and acute manpower shortages that exist in various specialties. I heard someone else speak just previously about psychiatry, and hopefully the continuing contract discussions will come to fruition very quickly. This is an absolute must. Other needs also exist in obstetrics and gynaecology, orthopaedic surgery, and we need more family physicians. There's no doubt about that.

But let me stress to all of you right now that conscripting a physician to come to northern Ontario is only a forced, unilateral, short-term solution, if any solution at all. I've seen over the last 15 years, through various

friends and family members, speak to me when I was in the capital of Canada about how their family physician turnover was happening so frequently. That's what you're going to get, nothing more, and that is not a solution. People will not stay. They'll come but they'll go. To continue in the solutions that you're suggesting of conscripting a physician to do so is to me unacceptable.

Incentives, however, or differentials, we believe, are more suited to such an end point. We have always supported locally and congratulate the government on actions guaranteeing minimum payment for physicians providing emergency on-call services in low-volume departments. But let us not stop. Long-term solutions must be developed. We need highly trained and skilled physicians who want to be in the north. We do not, I think, need to have physicians who have to be in the north because of a piece of legislation.

To do so, we would certainly encourage physicians in training to have rotations in northern communities during their training. This, I believe, and we all believe, will have a positive impact in the long term of attracting more physicians locally.

At this point I had hoped to have Dr Huggins present a summary of the OMA solutions on this topic, and I think you're pointing to him now. No? I'll leave that for now.

Let me go back to a local solution which is a physician-driven solution that has been put into practice only a week or so before Christmas. Over the last year we worked hand in hand with the hospitals of the district, and I'll be specific by naming them: Hearst, Kapuskasing, Iroquois Falls, Cochrane and the Timmins District Hospital. We realized we had to find a solution to being able to give our opinions on various images, X-rays or ultrasounds on patients who are at a remote distance to us, sometimes three to four hours. To do so, we took the time with consultations with various companies to look at what we can do with teleradiology. This is not telemedicine, per se, but it's similar to it. It's basically sending an X-ray image over a telephone line with a software package in a computer. Therefore, this in place now between these five hospitals.

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In addition to that, we have met with the vice-president of the Toronto Hospital and Dr C.S. Ho, the chairman of imaging of the Toronto Hospital, and they have supported and have agreed to buy the same technology we have. I stress that this is a physician-driven solution, not an imposed one. We have been able therefore to develop a computer linkup with software and telephone line between various cities in the community here, that I've just listed, to Timmins and from Timmins to Toronto. The logic is very simple: We will look at the images and we will talk over the phone and we'll come to solutions and differentials. That I think is the type of end point we should be aiming for in the problems we have to solve in the health care matters here today.

More specifically, I'd like to address a few points as they relate to the Public Hospitals Act and also the Independent Health Facilities Act, because as a radiologist and having colleagues that have private imaging clinics, I think these points also have to be discussed.

Firstly, the Public Hospitals Act: The delicate balance on Ontario's public hospitals between physicians and hospital administrators has been an important component behind the excellent level of care received by patients for decades. The Public Hospitals Act has served the interests of all concerned well by ensuring that the administrator's goals of efficiency and cost-reduction have been balanced against the physician's role as patient advocate.

It is the permanence of the physicians' appointments, subject to the very well-defined exemptions, that has enabled the physicians to play this role and to ensure that quality assurance and patient care are maintained at the highest possible level. It has also ensured that financial and other pressures are not improperly brought to bear upon physicians in an attempt to influence their clinical judgements, which must always be kept free from undue influence, so that only the best interests of the patients are considered.

Never in Ontario's history has this balance been more critical. In the face of the need to reduce costs in Ontario public hospitals, the need to have the physicians continue to act as the advocate of his or her patients is imperative. To disturb this balance and tip the scales heavily towards hospital administrators is to expose patients to the bottom line without any level of safeguards.

Once physicians may have their privileges revoked without cause, due process or recourse, there is nothing to stop any hospital administrator from exerting whatever pressure is necessary to ensure that any physician does as the administrator sees fit. Physicians may be told that they must discharge patients earlier, clinical judgment notwithstanding. Physicians may be forced to make a financial contribution to the hospital out of moneys paid by the Ministry of Health to the physician, even though the ministry paid such moneys in the expectation that this was intended as compensation for medical services. Besides being potentially a breach of professional conduct, regulations known as fee-splitting, it opens the door to all sorts of potential abuse.

In order to avoid the potential consequences of this destruction to the physician-hospital administrator relationship, the power to terminate physician privileges without statutory due process and without recourse has been reduced only to be applied where a hospital is being closed and only to become effective upon closure. Specifically, such power will not be available where two hospitals are merged or otherwise integrated and it will certainly not be available in any other circumstances.

At this point, I'd like to make comments as they relate to the Independent Health Facilities Act. The main reason for the introduction of the IHFA was to ensure a high standard of quality assurance in facilities governed by it. Through the joint efforts of the college, the ministry and key stakeholder organizations, the quality assurance program that has been developed is exemplary and a model to be replicated elsewhere in the health care system.

Concern has been raised, however, about the government's ability to enforce the same level of quality assurance against foreign-owned entities and to enforce rules protecting patient confidentiality against such foreign entities. In addition, concern has been expressed

with respect to the college's ability to enforce a high standard of quality assurance in non-physician-owned facilities or to enforce patient confidentiality requirements against non-physician owners.

Therefore, to ensure that the college has the necessary power to sanction those who do not comply with quality assurance standards or patients' confidentiality requirements, the ownership of those facilities, such as diagnostic imaging facilities, that provide medical services should in the future be restricted to those physicians with the specialized expertise in this area. This is consistent with the approach taken towards professional practices generally in Canada.

Existing licensees who are not physicians or physician-controlled will be permitted to continue to operate their already licensed facilities. However, any new licensees, including purchasers of existing licences and purchasers of the shares of a corporate licensee will have to meet the new criteria. By limiting ownership to physicians, it is expected that less emphasis will be placed on marketing and generating profits, and consequently it should lead to lower utilization.

Furthermore, most facilities which have been the subject of sanctions based upon poor quality under the act since its proclamation have been physician-owned.

Finally, it should also help to ensure patient confidentiality by guaranteeing that the college will have the necessary authority to enforce the relevant rules.

Dr Huggins has arrived.

Dr David Huggins: My apologies, folks; a sick child and a sick adult.

Dr Vezina: Good morning, Dave. I've left a few paragraphs for you as it relates to the OMA proposals to government to solve the problem of physician needs in northern Ontario.

Dr Huggins: My pleasure. Good morning, all. There were some concerning things actually that the minister stated some several weeks ago concerning the lack of the OMA's positive suggestions to influence life in the north as a physician. As you're probably well aware, we have proposed a number of proposals, including a northern incentive program to be funded out of the global budget of the OMA. We have proposed, since 1993, direct contract proposals. There certainly was some concern over the past several years as to who might pay for this.

The ministry's position has changed. The OMA's position has changed. We believe it's a valuable program. We believe it should have been initiated several years ago. However, we're still hoping that it will be initiated. Just for example, in this town we've got one psychiatrist. There's virtually no child psychiatry in northeastern Ontario—virtually, because I think there may be one and a half in Sudbury; I believe there are 50 in Ottawa.

We at the ministry—the ministry? God, it's been so long talking with them. We at the OMA do believe that we have some positive programs that are going to be much more successful than what the minister has suggested. I don't think we in the north really are interested in having doctors conscripted to come to the north. We think they may be poorly trained and ill equipped and not interested in coming here. We do recognize there's a problem in the provision of services in northeastern

Ontario and we think we have a better solution than has been suggested to date.

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The Chair: Okay. We've got about five minutes per party, beginning with the government.

Mrs Ecker: Thank you very much for coming here and taking time out of a very busy schedule to provide us with some good suggestions. I have two questions, one concerning the Independent Health Facilities Act.

I think Dr Vezina made a good point about the fact that if there's physician ownership, it might well provide a better way for the College of Physicians and Surgeons to police the quality of care and confidentiality. One of the things I'd be interested in your input on is that one of the concerns CPSO has had with physician ownership of things like the Independent Health Facilities Act is conflict-of-interest problems. I wondered if there is a way that could be better addressed, because I gather that has been creating a lot of concerns. It's a minority, it's not the majority, but there are some apparently who are creating some difficulties because of conflict of interest. Is there a way to address that?

Dr Vezina: I don't have the solution clearly in front of me to deliver this morning. I could agree with you that it is firstly a minority of situations, of imaging occurring in this way in the province, in fact the whole country. It has been much a bigger problem in the United States, as you can certainly understand.

Certainly as it relates to Ontario, I think if we agree that this is an objective we should aim for and if we agree there is a problem or a potential problem, we should sit down with the people who will be providing it with the CPSO and develop some guidelines to prevent this happening.

We have computers everywhere now. The ministry has computers everywhere. We can easily backtrack or look back or provide ways of perhaps monitoring that and minimizing it, if not removing it.

Mrs Ecker: Is there any way to do that sort of sharing of information and that kind of thing without getting into the sharing of patient treatment information among the ministry and the committees and that in order to try to go after that abuse and fraud?

Dr Vezina: I'm not sure of a yes or no to that. I would suggest that the OAR, the Ontario Association of Radiologists, as the leading group of imaging in this province would be able to provide sufficient suggestions to you or to anyone else who would like to look at that matter, but I agree with you that should be clarified, if that's the objective down the line.

Mrs Ecker: Just on the underserved area, which I think we all recognize has been a serious problem that a lot of governments have tried to wrestle with, the difficulty is that of course specifically in the last four or five years the number of underserved communities has increased something like 40%.

The minister has proposed financial incentives, enhancements to education and training, increased professional support. There's certainly a recognition and an acknowledgement that many of those recommendations that help address the isolation and the lack of support for physicians in the north might well be of assistance, and

that if that doesn't work, if there's not some time here, then billing numbers may well need to be looked at.

Given the fact that we've all wrestled with this, governments, the OMA and local communities over the last several years, is there anything new and different in the proposals that you've talked about that haven't been tried before?

What we're trying to wrestle with is that there have been things like incentives and things that haven't worked before, and I guess what we're trying to get at is what will work now that didn't work before. Was it just that there were recommendations there which previous governments didn't enact or are there things there we should be enacting and what can we do to make sure it helps so we don't need to use things like billing numbers, which I think everybody agrees is not the preferred option to go here? But communities are losing physicians at a great rate and we have to address that in some manner.

Dr Huggins: I'm encouraged to hear that the government is going to follow through with the incentive program. The incentive program was one that was initiated by the OMA, as was the CME program for physicians in the north. It was introduced under the 1993 agreement, as you're well aware. We're hoping that will continue to happen.

We're also very much involved in the production of the northeastern-northwestern family residency programs, which we think are excellent programs and need to be augmented. We have suggested since 1993 that there be increased circulation and exposure of specialists in their post-grad training programs to the north so they get exposed to what life is like and it is not all that terrible up here in the north. They actually come prepared perhaps.

Why hasn't it worked in the past? We think the incentives have been lousy. They haven't been changed since the UAP program was initiated back in the 1980s. We think it was inappropriate, inadequate. We think there are many things we can do to improve it.

Mr Miclash: I'd like to thank the doctors for appearing. I think what you've done here in your presentation this morning is just sort of extended what we heard earlier, that being the uniqueness of practice here in the north, that we do need some physician-driven solutions to the problems. We need a commitment on behalf of those who wish to practise in the north, who wish to come to the north, to remain and that commitment coming directly from them.

My question to you this morning is, being that we've had the present government indicate in a number of documents, and I quoted from a few of them this morning, that they would have consultation from people in the north, do you know of any individuals or groups that were actually consulted in the drafting of Bill 26?

Dr Huggins: The short answer is no.

Mr Miclash: Okay.

Mr Vezina: My answer is a big zero.

Mr Miclash: Thank you.

Mrs McLeod: Following that, I've been directly and indirectly involved in the whole question of physician recruitment and retention in northern Ontario for a long time now and I get more than a little frustrated at sugges-

tions that there have not been creative solutions that have been put in place and that are, in some measure, working, and you mentioned a number of them.

The residency program: Somebody says, "Well, why hasn't it produced results yet?" I think this is the first year that the graduates have actually been out in the field and the retention rate from that program is remarkably high. I think there is considerable encouragement from the incentives and, as you've indicated, there is sufficient encouragement that we need to look at enhancing the programs that are in place now.

I'm prepared to say that my anecdotal experience is that the biggest problem in retaining physicians in northern Ontario has been the outflux of physicians when doctors see the government stepping in to control health care. I'm wondering whether or not you are concerned about surveys of the University of Toronto medical school class, for example, where they said 80% of them would leave if the kinds of measures proposed in Bill 26 were brought in. Are you concerned that Bill 26, billing numbers notwithstanding, may in fact create an even greater problem for recruitment of physicians in the north?

Dr Huggins: Aside from the anecdotal, and the one comment we heard from the chair of general practice at U of T that a significant number of his grads were going to walk, in our community I believe that at the last count we're up to six physicians who have left within the last six months in this community, and I don't believe we have any sign on the horizon of a single replacement for any one of them.

Anecdotally is the best I can give too, but I believe there is a significant disinterest, if Bill 26 continues, in young physicians continuing to practise anywhere in Ontario, let alone where they might be conscripted to work.

Mr Ramsay: I would just like to say that about a year and a half ago, Dr Vezina, I was through your radiology department and was very impressed with what you've done here. It's a very good example of how not only physician-driven solutions but locally driven solutions and, in this case, a regional solution for northeastern Ontario, or at least a good part of it, seems to be the way to go, rather than the government from up on high, and especially from the minister's office, dictating policy. I think you're a very good example of how, when the pressures and needs are there, we in the north can come up with solutions and I'd just like to congratulate you for that program.

Mrs McLeod: I'll come back to the independent health facilities, which is another issue you raised, and since we're not in a court of law, we're allowed to make attributions. I wonder if you would comment on why you think the government would be dropping the Canadian preference in looking at who should manage independent health care facilities.

Dr Vezina: Probably opening it up to more people and liberalizing the use of that particular industry. If you open it up to more doors, in my mind, if this is what you're questioning, to me, it is a step in saying that maybe more of our health care will be opened up to US markets. Isn't that the way you read it?

Mrs McLeod: Yes, that's the way I read it.

Dr Vezina: That's quite simple.

Dr Huggins: The only other read is that it seems this is the only example in Bill 26 where the PCs are at all interested in free and open markets.

Mr Bisson: Just a couple of quick questions here. We heard some comment a little while ago by the Conservative member, Mr Clement, that they're waiting to hear what the hearings have to say in regard to the whole issue of releasing of confidential medical information. I would just remind people here and yourselves that if it hadn't been for the work of both the Liberals and the NDP in forcing this into committee hearings, we wouldn't even have the opportunity to do that, so I think it's a bit of a moot point that the member is making.

1150

The question I'm asking you is this. There are two parts. In schedule H of the act it says, "The minister may enter into agreements to collect, use and disclose personal information concerning insured services provided by physicians, practitioners or health facilities." Do you have any concerns as a professional in regard to what that might mean and where that might lead? And if you can, be a bit specific.

Dr Huggins: Obviously, we do. I think the average patient should have more concerns than I as a professional have. I don't think any government should have the right to know what your private medical file says. I think there is no question that governments need increased information in terms of managing the system. Providing there are absolute guarantees of anonymity, I think improved information accessing is useful, useful to government, useful to the provision of health care in the longer term. Currently, the way it sits, it doesn't give me much assurance, nor can I give my patients much assurance, that there is any degree of anonymity, in spite of the fact that it comes under the aegis of the privacy commissioner.

Mr Bisson: The second very quick question is that under the act there's going to be more of an ability for the government to decide what treatment that you decide that you want your patient to follow, based on the medical situation of that patient, or how you can treat them. Any comments on that, in regard to trying to find savings; in other words, delisting unilaterally certain services?

Dr Huggins: I'm not sure that just delisting unilaterally is the implication. What more of the implication is to me is that somebody may make a bureaucratic decision as to what is appropriate. What's even more appalling and more absolutely absurd in the legislation is that after the fact, after a service has been delivered, somebody can make a decision that it was not medically necessary to do so, in which case, according to the legislation, I would be responsible for having ordered the test, made the consultation referral etc.

On what basis can one, in any legitimate real world, have somebody, presumably a physician but there's no reference to a physician, making a second guess as to what it is that a service is going to be provided? It's absolutely nuts.

Ms Lankin: Just to follow up on that point, in the previous legislation if there was a review, if there had been a concern raised about some aspect of practice of the physician, it was a Medical Review Committee, a peer review, that would look at that and exercise that judgement around medical necessity, in consultation with the physician. Now it is somebody at the Ministry of Health in Queen's Park, not a physician, not a qualified peer review. Those concerns are very appropriate.

I have to tell you that last night I sat in the hotel room here reading through all of these, which are letters from physicians to their MPPs, the Minister of Health and the Premier. The concerns that they set out in there and their fear that there's a bureaucracy that's going to be making medical decisions and reaching in and the intrusiveness of that, instead of those decisions being made by patients and doctors together—even if that's not what the government intended, that's how people understand what is happening here, and what the impact of the actual words in the legislation are.

I just wanted to add some other information from your colleagues who have written here, because in fact many of them indicate that there is a growing sense that physicians are going to leave, not just the graduating physicians that you talked about.

This letter here from a dermatologist talks about—in fact, he's the representative for the section of dermatology for the OMA—and he says that he's received five phone calls in the last week from colleagues with seven to 10 years' practice experience who've begun an extensive search for relocation outside of Ontario.

There's another letter in here—I don't have it in front of me—where the physician has talked to a physician headhunter in Phoenix, who indicates that since Bill 26 has been tabled, the number of Ontario doctors that have contacted them and they're talking to has just blossomed, and that's one headhunter in one US city.

I don't have a specific question for you. I just think that the concerns that you've raised we're hearing from physicians right across this province. I feel in many ways like physicians have been scapegoated through this process and that it's almost like a divide-and-conquer, because many of the letters from physicians now sort of turn on patients and say it's patients who are driving increases in utilization. We're all being divided in response to how this government is behaving instead of trying to find common solutions, which would be a better approach.

The Chair: Thank you, doctors. We appreciate your interest in our process and being here this morning.

We have a motion to deal with at lunchtime that is in order. Just a couple of things before we get to that. Number one is we do have to check out at lunchtime; number two, there are some tables set up for us to have lunch. It is snowing heavily outside. The last plane out to Sudbury is the one we're scheduled on. In view of those issues, can I have unanimous consent that we will limit the discussion on the motion to one five-minute conversation per party and then vote on it?

Mrs McLeod: What's our time frame to get to the airport?

The Chair: We've got an hour.

Mrs McLeod: From the end of the committee hearings until the flight leaves?

The Chair: Right.

Mrs McLeod: And it's what, a 20-minute trip to the airport under good conditions?

The Chair: It's snowing heavily outside. We do have to get to Sudbury.

Ms Lankin: I will agree to that. I'd just like to split my five minutes to an introduction and a wrapup.

Mrs McLeod: I'm not sure that we need to curtail the presentations. I think we should perhaps check with norOntair as to whether or not—

The Chair: We do have somebody scheduled at 1 o'clock. We do have to check out, we do have to have lunch, and I think it's important that we do those things. I'm just talking about the debate on the motion that Ms Lankin introduced.

Mrs McLeod: But not on the presentations after that.

The Chair: Oh no, no. I'm sorry, my mistake. One five-minute conversation per party on the motion. Everybody agree with that? Okay. Ms Lankin.

Ms Lankin: Thank you very much. I have moved this motion today because I think it is important that we continue to drive home to the government the concern of people in the province of Ontario with respect to this bill and the concern with respect to the process and the fact that many, many people who have put forward their names to present before this committee and the other committee that is travelling in these next two weeks won't be heard.

Prior to Christmas, when we discussed the concept of whether or not there should be more hearings and whether the bill should be split etc, the government members simply said that they didn't think there would be that much of a problem, that people would have an opportunity to be heard and that it was premature. Well, let me say that since that time the numbers of people who have applied to be heard have increased. In my motions before Christmas, we were referring to hundreds of people who had applied to be heard. Now there are 1,026 groups and individuals who got their names in and applied before the deadline and before the cutoff, and we've received numerous calls from people who missed the deadline and the cutoff and were still trying to get on. That 1,026 number is just for these two weeks of out-of-town hearings, and—I have alluded to this earlier—there are only 274 spaces that are available for people to be heard. So you can see by how much the demand outstrips the time available.

Particularly as we're travelling in the north, you can see that—for example, you mentioned the last flight out of here is at 4:30 today. We've had to cut the day short and stop at 3 o'clock in the afternoon, whereas in Toronto, for example, we would have gone on till 6 or till later into the evening. So northern communities, when we're only here for one day, are not getting the same kind of access as other communities are. We're cutting short the north in terms of the amount of time available. When we go into communities like Sudbury tomorrow, there are 13 spots available. There is something like 56 or 58 people who have applied to come forward. This is just not acceptable in terms of a democratic process.

I know the government members know that I believe the bill needs further consideration and that it should also be split up so that we deal with it adequately, and that we're prepared to pass the parts that are urgent and need to be passed on the 29th. I would urge them, after having heard over the break the number of people who are wanting to come forward, to reconsider the position they've taken on this motion in the past and to support it so that we can at least simply ask the government House leader to meet with the other House leaders and to discuss this issue and to attempt to come to a better process resolution to dealing with this very important bill and the major public concern that is out there.

1200

Mr Clement: I do not support the motion, Mr Chairman, for the same reasons for the previous six motions Mrs Lankin has put forward with very similar wording, or whatever the number. Maybe it was four or five, but it sounded like six. I'm sorry if I sound facetious; I don't intend to, Mrs Lankin, but just as Mrs McLeod is frustrated with our interpretation of the bill, I get frustrated by the myth-making that is occurring by the opposition respecting the lack of hearings. For instance, Mr Bisson and Mrs Lankin, I believe, earlier indicated to the public that the government side was not in favour of hearings on the bill and it had to be forced through the opposition. That is absolutely incorrect.

Interjections.

The Chair: Excuse me. Mr Clement has the floor. He did not interrupt Ms Lankin, so I appreciate the same consideration for him.

Mr Clement: As my honourable colleagues well know, in fact the government House leader, Mr Eves, suggested to the other House leaders that we have 360 hours of hearing time. As it stands, Mr Chairman, we on both sides of the committee, both the health and the non-health side, will have heard at the end of this process by my calculations 750 separate presentations. There is also an opportunity for written presentations, which we have been receiving and have been reading. We are visiting 11 cities in 10 days to hear from other persons in Ontario who wish that their views be recorded, and in fact this is what this process is all about.

If I'm evidencing frustration, Mr Chairman, I do not wish to project that to my friends and colleagues on the other side, but it is simply that we are going through a process which is legitimate, which will allow for differing points of view to be heard, and we've heard some today, and that's what this process is all about, quite frankly. At some point, as the House leaders have agreed, government has to come together with the opposition parties in the Legislature, the duly constituted democratic body in this province, and decide on legislation. That date has been scheduled for January 29. That was agreed to by the opposition House leaders, and we intend to stick to the agreement that was sanctified by the Legislature.

Mr Miclash: I think as we travel throughout the north the government members will find out that there is a fair amount of uniqueness in the north and at this time I would just like to welcome you to the north. I haven't had a chance to do that yet, but it only shows you that out of 35 requests in Thunder Bay alone we're going to

listen to 10 only. Had we not travelled to the north, we probably wouldn't have even seen any of those 10. So I really have a concern for that. I would just like to say that I've heard there have been up to 1,200 groups out there that have requested time at the hearings. As Ms Lankin has indicated in her motion, there have only been 274 spaces allotted to some 1,200 groups.

As we continue into the hearings, we understand there is more and more interest in this bill, one which is flawed to a great amount, noting just the announced amendments that the minister is talking about presently and the ones that we're looking for. When you take a look at just some of the responses of the ministers in the House over the last week of the Legislature, you have to realize the need to listen to this great number of groups, because one minister in particular didn't know what the bill contained. That even shows us the need to ensure that all of these groups have a chance to say something to the bill. So I would just like to say at this time that we certainly would like to see more than just one fifth of those who have requested to present on the bill to be able to present to this committee. We fully support this resolution.

The Chair: Thank you, Mr Miclash. Okay, the—

Ms Lankin: Just the wrapup.

The Chair: We said one speaker, a maximum of five minutes. What's what we agreed to.

Mr Clement: No, but she wanted to have the beginning half.

The Chair: Yes, Ms Lankin.

Ms Lankin: Just very quickly, in response to Mr Clement's comments, number one, I'd like to raise a point of privilege in terms of violation of rights of the member. He indicated that the committee has received written submissions from people and that he has been reading those. I have not received one copy of a written submission, and if the government members have been receiving them and the other parties have not had them circulated to them, then there is a problem. I have not received any that have been sent through, so I don't know what that's about but we can deal with that separately as a matter of privilege.

With respect to his comments that the government had offered more hours of hearings, again I want to point out the myth-making here. In the week leading up to December 14, when no one had copies of the bill, when no one had done the analysis, when the public didn't even know what was in it yet, when people had had only knowledge that had been introduced a week before that, I just think it's really inappropriate to continue to put that myth out.

Lastly, you say that the agreement was reached. Let me tell you, it was forced through the action of the opposition parties, and the final agreement was one that we barely could reach between the three parties for January 29. Since that time, we have found out what the response of the public was. We didn't know there would be that many people who wanted to come forward. That is reason enough for any reasonable people, particularly those accountable to the public, to rethink the agreement. That's all I'm asking, that they meet and they rethink it.

The Chair: The motion has been put.

Ms Lankin: A recorded vote, please.

The Chair: All those in favour of the motion?

Ayes

Lankin, Miclash.

The Chair: Opposed?

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated. We recess until 1 o'clock.

The committee recessed from 1206 to 1309.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION NORTHEAST AREA COUNCIL

The Chair: The first presenter for this afternoon is the Ontario Public Service Employees Union, Northeast Area Council. Helen Riehl is the chair. We had made a decision that we would begin on time, regardless of who was here to listen. I've given them an extra 10 minutes, and we're still a little short, but they will be coming in as your presentation is going on. So I think in the interests of time we'll let you get started. You have a half-hour to use as you see fit. Any questioning time at the end would start with the Liberals. So the floor is yours.

Ms Helen Riehl: Okay, great. I'd like to start by thanking you for giving me the opportunity to make this presentation. I'd also like to let you know that I am a front-line worker. I work in the community of Timmins with the developmentally handicapped, and I've been working there for approximately 15 years.

The Northeast Area Council represents about 1,000 people in the city of Timmins and an additional 1,000 people in the areas of New Liskeard, Kirkland Lake, Haileybury, Kapuskasing, Chapleau, Foleyet, Moosonee and surrounding area. We are members of the Ontario Public Service Employees Union and work either directly for the Ontario government or in the broader public sector.

We are very concerned over Bill 26 and its consequences, not as only as workers but also as taxpayers and users of the service. This bill is clearly about the privatization of services. In regard to health care, the power that is taken away from the people and given to the Minister of Health is alarming. The minister will have the power, at his discretion, to administer grants, loans or financial assistance, with the added power of reducing, suspending, withholding and terminating assistance. As well, the minister will have the power to impose terms and conditions and set requirements for the repayment of loans.

The minister will have the power to dictate what services may or may not be offered, to close or merge hospitals, and to order that a hospital cease operating as a public hospital. All of these powers are given without the need to consult or to have public hearings. The closure of one hospital in the north would have a large impact on the citizens, and it is unthinkable that a decision such as this could be made without hearing the concerns of the people.

Prior to Bill 26, an investigator could be appointed by the government to report on the quality of care, management and administration of a hospital. Based on the report of the investigator, a supervisor might be assigned to act as an adviser to the hospital board and administration for the purposes of improving the management and care of the facility.

This bill would allow a supervisor to be assigned at the discretion of the Lieutenant Governor, with no connection to an investigator. The supervisor reports to and follows the direction of the Minister of Health.

Bill 26 virtually gives the minister the power to make any changes to the hospital that he feels is in the public interest, and I emphasize "he." This is from a government that says it wants to get out of the business of running business.

Prior to this bill, these powers were not left to an individual. How can one person decide what is in the public interest for the people of this province? That is an attack on the democratic rights of the people.

The powers given to this minister will result in groups having to do extensive lobbying for the hospitals in their areas. It's very difficult to lobby effectively in a province the size of Ontario. You need a lot of money, a lot of time and a lot of people. You need to be close to those you are lobbying. How are the people in northern Ontario able to effectively lobby the minister in Queen's Park?

Another very disturbing fact is that the minister and cabinet are protected from any liabilities as a result of their decisions. I thought the government was supposed to be accountable for its decisions.

The minister will also have the power to revoke a private hospital licence or reduce the level of government financial assistance. This will open the door to private, for-profit hospitals. When agencies are run for profit, the ability to provide quality care is diminished by dollar signs. With the added proposal to remove the preference given to Canadian-owned, non-profit facilities, it is clear that the hospitals will be run by out-of-country agencies. This will only take money out of the province and lower the tax base.

These corporations are only here for profit. They will not want to run routine tests due to the cost and time that it takes to do so. If we allow this to happen, we would be setting ourselves up for outbreaks of epidemics such as diphtheria, which is presently a routine test done by the provincial health labs. If we look at past experience, we can see that private, for-profit services cost approximately 34% more than publicly run services.

The need for continued profits creates an unduly stressful environment in which to work. I heard a story that I'd like to share with you from a co-worker who worked in a hospital in the United States. This hospital would frequently receive patients from nursing homes in the area. They had large bed sores and it was obvious that they hadn't been bathed in days. This person was concerned about that. When she brought it up to her supervisor and asked about filing a report, she was told to keep her mouth shut because if there was a report filed, the nursing home would no longer send people to that hospital and that hospital would lose profits.

I don't think that's what we want to see in Ontario, but I think that's what will happen if this bill proceeds. I'm amazed that we would be looking towards an American-type system when they are looking to us for ways they can improve their system.

Another issue that appears not to have been given much thought is one surrounding the terms of the North American free trade agreement. It's my understanding

that under NAFTA, once a service is privatized it cannot revert back to a publicly run service. What is this government going to do when it realizes that privatized services cost more money? By that time it will be too late.

Schedule G of Bill 26 is another area of concern. This directly affects the people I work with. These people need medication to sustain a quality of life. Some of them are on as many as 12 prescriptions a month and they receive a personal needs allowance of just over \$100 a month. They cannot afford to pay extra money for prescriptions. This part of the bill will place some people in the situation of having to decide whether to buy food or fill a prescription. Some people need medication to prevent them from injuring themselves or others; without it many will end up in jail, in the hospital or on the street. Not filling prescriptions due to the deterrent of cost will increase the need for crisis intervention, hospitalization and long-term treatment.

The deregulation of drug prices will result in the overpricing of medication and, again, people on fixed incomes will have to decide if they should fill a prescription or if they should buy food for the table. People who have benefit plans will face higher premiums. Why does Ontario have to be the only province that does not have regulated drug prices?

Schedules H and I will present changes to the definition of "medically necessary." This was previously negotiated with the Ontario Medical Association and defined by regulation. Once again the minister will have the authority to determine what is insured. This will create a two-tiered system, with minimum care for the majority and extensive care to those who can afford to pay for it. I can't imagine being seriously ill and having to decide if I can afford to purchase the care that could save my life. The changes to this bill have very serious repercussions for the citizens of Ontario. The changes are being made far too fast and with little thought to how the majority of the people will be affected.

During the election campaign, Ontarians heard promises that were made and printed in the Common Sense Revolution and distributed by the hundreds of thousands. The promises voters heard were clear: "We will not cut health care spending; health care spending will be guaranteed; health care funding won't be touched; aid for seniors and the disabled will not be cut; how the savings will be achieved will be discussed in partnership with all Ontarians; our four-year plan will be based on analysis and consultation with workers and ordinary Ontarians through extensive public hearings; there will be no new user fees and we will work with OPSEU members, listening to their ideas and eliciting their help in taking action." This bill breaks every single one of those promises. We urge the government to meet its promises and repeal this bill.

The Chair: Thank you for your presentation. We've got about five or six minutes per party left for questions, beginning with the Liberals.

Mrs McLeod: I appreciate your presentation and the time you've put into it. One of the things that strikes me is your concern about increasing privatization of health care. That's one of the things we worry about as something that can happen down the road with this bill.

There's so much that concerns us that will happen immediately that sometimes it's hard to look down the road and say, "What's the long-term impact of this?" I personally think you're right to be concerned that what we could see here is an increasing privatization of health care and that it would more and more become one system for those who could afford the best and another system for those who can't afford to get something more than the public system can provide.

It all comes at a time when there is real funding pressure on the public health care system. You're right to quote some of the promises the government made before they were government, because not a penny was supposed to come out of health care, and we're looking now at a budget that takes \$1.5 billion out before we see any real evidence of those dollars being replaced. Our concern—and I think you've reflected on that—is that if you're really squeezing the public system, the pressure to let the private system in becomes almost overwhelming.

I also appreciated that you picked up on the fact—you obviously work in a long-term-care setting; at least, I gather that from your presentation—that the copayment for drugs becomes really punitive for those who are on a relatively small comfort allowance. I appreciate your picking up on that.

1320

Knowing that the health care system is under financial pressure—even if the government weren't trying to take \$1.5 billion out of it, there'd still be some real financial challenges to meet the need that's there—do you as a front-line worker see changes, ways dollars can be saved, ways we can meet the needs without new dollars in the system? Do you see an opportunity for people in a community like this one to work to find those kinds of changes without the government having to step in and do it in a heavy-handed way?

Ms Riehl: Definitely the front-line workers have ideas of how savings can be achieved, and I think it's only through talking with them that you'll find the best way to do it, because they know how to achieve the savings without affecting the service.

Mrs McLeod: Is that kind of consultation happening? I suspect it hasn't happened on this bill.

Ms Riehl: No, I don't see it at all. I saw it prior to June, but I don't see it now.

Mr Michael A. Brown (Algoma-Manitoulin): I'm interested in the process here. One of the most interesting things about this process is that this is obviously a major bill dealing with not only health care but myriad other subjects.

I'm the Natural Resources critic for the Liberal Party, and I was in the last Parliament also, and we went through a rather major forestry bill, Bill 171, which a lot of people here in Timmins would know about. During that process, we did three weeks of public hearings on that bill, and the opposition, led by Mr Hodgson, the present Minister of Natural Resources—both Mr Hodgson and I said, "We won't start unless we get the manuals, the regulations; you've got to show us what they are before we're willing to start," because it gave the minister huge discretionary power, much like this bill does. Well, we got the 1,000 pages of manuals and regulations,

and I assume this bill will generate more than a thousand pages of manuals and regulations.

My question follows from Mrs McLeod's question. Has your organization, you personally, the community, had any kind of input into the development of these regulations? Have you seen any regulations that this bill might be implementing and how that really affects it? Even if we believe our good friends across the floor here that everything's going to be fine and swell and wonderful, do you know what? They're not going to be there forever, this minister isn't going to be there forever, and whichever minister inherits this bill then gets to do whatever he or she wants. Even if we believe what they're saying, the powers given to a minister under this bill are absolutely incredible—most would say outrageous. Have you had any dialogue about what they intend to do at this juncture?

Ms Riehl: No, I haven't. I agree with you that the bill is far too large and the regulations will be far too detailed. It's really being rushed through. To want to vote on it at the end of this month and rush through these types of meetings—you need to listen to far more citizens of Ontario to get a full picture of what the citizens of Ontario feel and how they feel this will affect them.

Ms Lankin: We certainly appreciate your presentation. Helen, where do you work? You mentioned the clients you work with.

Ms Riehl: I work for the Cochrane-Timiskaming Resource Centre. It's a schedule 2 facility for the developmentally handicapped.

Ms Lankin: In that community and in the broader community that deals with people who have mental health problems—that's a little different from the developmentally handicapped area, but I'm interested in the concerns you raised about the copayment. I think I heard you touch on two issues. One was that for those who were in some kind of collective living situation, and that would be the same for seniors in nursing homes, for example, who are without financial resources and are living on a comfort allowance in terms of any additional purchases they need to take, the copay would come out of that money.

From your experience I'd like you to elaborate what it would mean for those people. What sorts of things do they do with that comfort allowance now that they won't be able to do when they pay that \$2 per prescription? You said some of them are up to as many as 11 or 12 prescriptions a month.

The second thing I thought I heard you touch on I've heard some people working with clients in the mental field raise, and that's the issue of drug compliance. As we try to move away from such reliance on institutions and to support more people in our community, in the mental health field in particular, one of the things we know is really important is support in working with them for medication compliance. The concern has been raised that the \$2 copayment will be a tremendous deterrent for some of these people who are very marginalized in terms of their economic power, that it could lead to a lack of compliance which then becomes the revolving-door problem of people becoming reinstitutionalized.

Could you just elaborate on those two areas for me?

Ms Riehl: The comfort allowance is used to purchase personal hygiene products, to have haircuts, to go to the movies, go out for supper, anything other than what's necessary, like food and shelter and medication.

The compliance with medications—we have a lot of people who are epileptic and who have behaviour outbursts, and that's controlled somewhat by medication. If they didn't have that, they'd be at risk of becoming aggressive, hurting themselves, hurting others, as well as the staff who work there. For people who are epileptic, even with the medication they're on their epilepsy is not completely controlled, and they can have maybe a dozen or so seizures a month. It would substantially affect their quality of life if they were unable to purchase the medications.

With the push to have more and more independent living, some of those choices are left up to the individuals themselves, and if it means, "I can buy a chocolate bar and a pop or I can get my prescription," they're going to buy a chocolate bar and a pop.

Ms Lankin: You're talking about someone in an independent living situation out in the community.

You just raised a question that we haven't talked to anybody about during these hearings. For someone who is living in a home, an institutionalized setting, currently staff are involved with them in terms of medication compliance, I'm sure to try to help control the kind of—

Ms Riehl: In most agencies, yes.

Ms Lankin: Do you have a mechanism? How do you get someone to take the drug if they don't want to? At least right now you've got the drug there. Will there be any mechanism for you to force them to spend their comfort allowance to pay the copayment to get the drug in the first place? What if they don't even have the drug? Do you know how that plays itself out?

Ms Riehl: I think it would depend on how the agency is run. In some agencies those decisions would be left up to the individuals alone, and in other agencies it would be up to the staff; the staff pick up the medications and deliver them to the homes. In some agencies it would be easier to ensure compliance than in others.

Mrs Johns: Thank you for your presentation this afternoon. Obviously there are some things we agree with and some things we disagree with. I thank you for bringing up about the medication. We've heard that a number of times, and the \$2.

I think one of your fundamental premises today was how fast we're moving and why we need to move so quickly. I'd like to address that for a moment, if I may. The province spends \$1 million more an hour than it receives in revenue at this point, and at this point, we worry in the long run that if we don't make some tough choices today, there will be no health care in the future, there will be no education in the future. As a younger person, especially in my case where I have young children, I really worry about where the health care will be tomorrow if we don't make some decisions today, decisions that are hard, admittedly, but that will put Ontario in the position where it will be able to compete and we'll be able to have health care in the 21st century.

We worry that there will be a two-tier health system, obviously. We worry about it as the ability of people to

have health care, that people can't as a result of not having doctors. I come from rural Ontario, and as you come from northern Ontario, I know you understand the problems with having physicians in our areas to take care of us.

You talked a little about emergency in the hospitals, and I want to touch on this. First of all, I'd like to say that we are trying very hard as a government to get emergency rooms open. We have made the first stand in paying the doctors \$70 an hour to man emergency rooms after hours and on weekends. We are making some stance; that's a reallocation we're making back into the health care system.

We've closed beds previously in previous governments, we've tried to make some changes. Nothing has happened or not enough has happened. We haven't been able to close those hospitals. You say you have some suggestions, and I know the people who work in health care institutions do have suggestions, but nothing's happened in the last 10 years. Why should we give it a little more time before we start to close the hospitals? What do you think will happen that hasn't happened up to this point?

Ms Riehl: I think all that's going to happen with this bill is that all the hospitals in the province are going to be privatized and for-profit and they're going to be American-owned and American-run. That's going to make a worse health care system than we've ever had in the province of Ontario. If you don't consult with the workers and the people on the front line, who know how to save the money and keep the service, it's not going to change. And it was coming, it was changing.

Mrs Johns: We obviously don't believe the system is going to become an Americanized system.

Ms Riehl: Could you guarantee that in writing to the citizens of Ontario?

Mrs Ecker: I didn't run as an MPP in this province to turn the Ontario health care system into an Americanized health care system. That's one of the reasons I'm here, to make sure that the changes we can make will save that system so it won't become Americanized.

The Chair: Thank you very much. We appreciate your interest in our process and your presentation.

1330

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, LOCAL 645

The Chair: The next group is the Ontario Public Service Employees Union, Local 645, represented by Doug Heath, who is a music therapist in the psychology department of the Timmins and District Hospital. Welcome to our committee. You have a half-hour to use as you see fit. Any time you leave for questions will begin with the New Democrats. The floor is yours, sir.

Mr Douglas Heath: Mr Chairman, honourable members of the standing committee, I would like to thank you for allowing me the opportunity to express the feelings of my fellow employees at the Timmins and District Hospital. I understand there was some doubt that these public hearings would take place, as occurred with Bill 7, and thank the members whose lobbying made this possible.

Bill 26, a rather massive bill, repeals two acts, creates three new ones and amends 44 pieces of legislation. Included in this bill are articles that give the government autocratic powers that bring about fundamental changes to our health care system. Bill 26 gives complete power to the Minister of Health to make changes to hospitals, physicians' conditions of work. It even allows access to patients' confidential records.

This bill will eliminate provisions that give preference to Canadian-owned, not-for-profit health care. By deregulating drug prices and allowing drug companies to determine the price for drugs, they will surely go up. Competition will not keep drug prices down because of the patent protection of Bill C-91.

Schedule F: Under section 8, the Ontario Council on Health is replaced by the Health Services Restructuring Commission. The Ontario Council on Health's role was to advise the minister on health matters and the needs of the people of Ontario. The commission will perform "duties assigned to it" with immunity from liability. We feel this is truly the function of our district health council. Mr Wilson stated that the commission will facilitate restructuring of the health care system by working with local communities to implement their restructuring reports. Mr Wilson has also recently instructed local planning bodies to submit their restructuring plans now, with or without consulting the stakeholders.

Timmins and District Hospital has worked hard at reducing its deficit and now has achieved a balanced budget by working together with all stakeholders. This bill will enable the government to make decisions that adversely affect health care in this community and district.

Bill 26 says the Minister of Health can make "any direction related to a hospital" that he wants, as long as he considers it to be in the public interest to do so. According to this bill, the public interest is defined as what is of interest to the Minister of Health 500 miles away, not what is of interest to the stakeholders who reside in the community. What is an appropriate solution to a situation in Toronto usually does not work in northern Ontario.

Changes to the Private Hospitals Act in sections 5 and 6 repeal the language that directs the minister to give preference to Canadian-owned non-profit facilities. With these changes, the Minister of Health will be able to selectively request proposals from foreign firms which are just waiting to acquire the lucrative Canadian health care business.

For example, look at the issue of funding and ownership of private laboratories in Ontario. Hospitals are funded for laboratory work out of their global budget. They are not permitted to bill OHIP on a fee-for-service basis as private labs do. It has been shown that private sector medical labs are 34% more costly than their hospital counterparts. In fact, recent research proves that if hospital laboratories were allowed to compete fairly with private labs—in other words, bring the services back into the outpatient clinics of our hospitals—the government would save \$106 million annually and our hospitals would get \$318 million in new funding. Over the last 20 years, the private labs have expanded their business in

Ontario to the point where they were billing the Ontario government close to half a billion dollars a year in 1993.

The laboratory outpatient pilot project of 1980 included Laurentian Hospital. They set up a collection depot in downtown Sudbury. They started the project one month late but still made \$304,968 in outpatient billing from February 1 until August 31, 1981. The profit of \$206,968 was divided 50-50 between the Ministry of Health and Laurentian Hospital. According to Dr Raymond Bonin of Laurentian Hospital, most of this work came from only nine physicians.

In 1990, the Ontario Hospital Association moved and passed the following resolution:

"Therefore, be it resolved that the OHA make representation to the Ministry of Health, to permit hospitals to bill OHIP for outpatient lab services on a basis similar to that extended to private laboratories, and in a manner similar to the way in which hospitals handle the billing for radiology procedures."

At Timmins and District Hospital, we strive to provide our patients with the best quality of care, which includes convenience. When patients are going to be admitted to hospital on a non-emergency basis, they attend a pre-admission clinic where X-rays and all workup are done, except lab work, prior to being admitted. Then they have to go to another part of town for their lab workup at a private laboratory. This is not convenient and does not meet the one-stop-shopping concept we have. Parking is a problem in this area, as is the extremely cold weather, often -40 degrees Celsius. This does not make for a pleasant experience. As a point of interest, we in northern Ontario usually experience temperatures 20 degrees or more lower than in Toronto.

We also have had situations where lab work completed at a private lab in the day had to be repeated in the evening when patients have been admitted on an emergency basis, as these reports have not been available, resulting in added costs to our health care system. Other costs that must also be assumed by hospital laboratories include over 400 tests that are done by hospital labs but are not performed by private labs. Private labs tend to perform the most common, standard tests that can be done easily in volume and can be automated. These tests are done with no additional funding, at a mean substantial cost to hospitals that the private laboratories do not incur.

Dr Mazzunchin, a member of the steering committee on hospital laboratory financial reform, in his report released on December 12, 1995, using data obtained from the 1994 laboratory services review, proves that hospital laboratories have lower costs per test than private sector labs. The data show:

(1) The hospital sector performs 1.6 times more work than the private sector.

(2) The hospital sector employs twice the number of professionals than the private sector.

(3) Even though the hospital sector employs more professionals and technologists, its cost per test is still \$1.40 per test, or 20.6%, less than the private sector.

The opportunity to have public lab dollars put back into the operating budget of a hospital is a much better way of utilizing tax dollars than going to private industry, some of which is not even Canadian, as is the case of

Dynacare, an American company which is operating Toronto Hospital's labs. All of these regulations seriously impact on the universality and accessibility of health care services, of medically necessary treatment and medication, for people who need support.

Schedules H and I amend the Health Insurance Act and the Health Care Accessibility Act, and create the new Physician Services Delivery Management Act. These changes will allow the minister to determine that certain services will not be insured unless provided in or by designated facilities. This constitutes a serious threat to our hospital and the people of our district in that excessive travel will limit access to treatment within our area. Schedule I gives the government enormous powers over health care delivery which will affect the availability and accessibility of health care services.

1340

The government, in its Common Sense Revolution, has made promises that it would not cut health care spending, that health care spending will be guaranteed, that health care funding won't be touched, that aid for services and the disabled would not be cut, that we would discuss how savings would be achieved, that there will be no user fees. We feel that this bill breaks all these promises.

Thank you again for allowing me to express my concerns regarding the future of health care.

The Chair: Thank you. We've got six minutes per party for questions, beginning with the New Democrats.

Mr Bisson: There was a comment, I think made by Mrs Johns—and I know I've heard Mr Clement make the same comment out of Toronto when I was watching it over the parliamentary channel—that without this bill, reform can't happen in the health care sector, because which hospital on its own would do this stuff unless forced to go through it.

I guess it angers me because I know the work that the Timmins and District Hospital has gone through over the past number of years, first of all amalgamating a number of hospitals together, then going through the restructuring that you did over the last three years, and on top of that the closure of the chronic care unit in South Porcupine, all decisions made by a local board in light of the financial situation that it finds itself in.

What do you say to somebody who doesn't recognize the work and the value that you have done within the health care sector as hospital workers and as administrators in regard to trying to find efficiencies on your own, without having them dictated from Toronto?

Mr Heath: I feel the work the Timmins and District Hospital has done as far as balancing its budget and making changes to help the patients in the service area that we provide service in has been phenomenal. We don't need individuals from southern Ontario who are appointed as "supervisors," I believe the term was in the bill, if I can refer to it, coming in and telling us what is best for the needs of northern Ontario.

We have acted very responsibly in the administration of our hospital. The unions, the stakeholders, the people who are receiving treatment have all consulted together, have developed means of trying to save money and have achieved a balanced budget, something that we did not believe was possible a number of years ago. We're very

proud of that and at this point in time we don't need regulators coming from Toronto telling us what we need to do with our health care system. Our mechanisms that we have in place now, including the health council, I feel are doing an excellent job.

Mr Bisson: Has it been easy, just maybe to put it in perspective? Because you're right. I remember being first elected and having to deal with this when my colleague was the Minister of Health. You were one of the people who was opposed to the change and worked eventually within it to make the changes that have come.

The comment I would make is that I find it highly insulting, knowing the work the hospital has done here, the unions have done here, the patients have done, the doctors have done, to be told that we need to be dictated to from Toronto, rather than trying to find local solutions within our community. It's highly offensive to the work that you have done as unions, to the work that the administration has done and the hospital board has done in being able to balance their budget. I just wanted you to keep in mind that the city of Timmins is actually very responsible and doesn't need to be dictated to by the city of Toronto on how we should be running our hospitals. We can live within the confines that the government puts in, but allow us to make our own decisions locally. I just would want to say that.

Mr Len Wood: I was there during the election campaign when Mike Harris was travelling through the north, saying that health care would be protected. The cuts they're doing now, he never talked about during the campaign, and yet we find out six months later the cuts that there are to health care, the cuts that there are to hospitals, the cuts there are to services.

As a matter of fact, even the snowplowing on the roads is being reduced, making it unsafe for people to travel on the roads. The airline is being shut down so that people are going to be isolated in their communities. NorOntair is not going to be travelling any more in the next little while.

Everything that he said he was not going to do as far as cuts is being done now, six months later. I know the frustration that we've had from everybody making presentations.

I want to ask the question that was asked earlier of another group: Was there consultation with anybody in your group on the cuts and slashing and the firing of people that is going to take place? I understand up to 26,000 people could be fired within the hospital system with Bill 26. Has there been any consultation up to the introduction of the bill?

Mr Heath: No, there has not been any consultation. We were very hopeful at one point in time with the announcement that there would be a central pool that hospital workers could be placed into, where first job allocations would be available to them in other sectors of our province. Unfortunately, with the HSTAP program no legislation was ever put in place to legislate that this central pool be utilized. From the last things that I've heard with regard to it, it's basically on hold and nothing is happening with regard to allowing hospital workers who are highly skilled and highly trained with tax dollars to be utilized in the province.

Mr Clement: Thank you very much for your presentation. I share some of your concerns, although your conclusions as to how to rectify that differ sometimes from the avenue I personally would like to pursue.

Let me just give you some assurance that public hearings would have taken place prior to the deal that was arrived at with the three House leaders in the government, that we had every intention of having public hearings at every stage of the process. I wanted to correct the record—

Mr Len Wood: You wanted to ram it through like you did Bill 7.

Mr Clement: I guess I'm eliciting some response from the partisan side opposite, which is fine; that's democracy. But I did want to correct the record on that.

Mr Len Wood: You were going to dictate it as you did with Bill 7, no consultation at all.

Mr Clement: Obviously I've struck a very delicate nerve on the other side there, but I did want to plow forward with a question or two.

You evince great concern over the sections of the bill dealing with the independent health facilities and whether there would be preference for Canadian owned versus not Canadian owned. I'm just trying to think this through myself as well as to what the potential scenarios are. What if there's a patent on a piece of equipment that is owned by a company based in Milan, Italy, let's say, and this piece of equipment can really deliver much better health care service for less? They don't particularly want to deal, for whatever reason, with Canadian-owned operations; they want to deal with Italian-owned operations. Aside from the potential loss of union jobs if they want to go with non-unionized, let's say—and I can understand your personal concern about that—what harm is there in having that entrant into the health care system so that we can get better health care for less for patients?

Mr Heath: I think one of the things we have to look at is maybe the case of MDS Laboratories with their MDS multilab now, the major centre they have. I believe over \$10 million was invested by the Ontario government in research for automation, for robotics, for MDS Laboratories. At one point in time, Sunnybrook Hospital had a private laboratory. It has now been taken over by MDS, and unfortunately this multilab, this huge multilab that is now roboticized, and at the expense of the Ontario taxpayers, is taking money that could have gone into a hospital global budget to help run that hospital and putting it into private sector pockets. This private sector profit I believe should be used to help the people of Ontario within their hospitals, not going into multicapital corporations.

Mr Clement: I know this sounds hard to believe, but sometimes the private sector can do a job better than the government can, and if that saves us taxpayers' money, I'm all in favour of that. In fact, I wanted to talk to you about that.

I noticed the report of Dr Mazzuchin. I guess I haven't read this yet; it was released December 12, 1995. Dynacare happens to have a plant in my riding of Brampton South where they hire dozens and dozens of Bramptonians. They're not Americans as far as I can tell; they're full-fledged Canadians, many of them new to this

country, and they work at the Dynacare lab there. The data they shared with me indicated that they in fact can do better for less. So I'm quite anxious to see this report and its definitive-seeming conclusions. Do you know the extent of the research that was done on this?

Mr Heath: Yes, I do. "Test Case: Private versus Public Laboratories." This is a large document, as you can see, where they've gone through, listed the expenses, listed the profits that they have made with regard to private versus public laboratories. I'm sorry you haven't had a chance to look at it yet, but I assure you that if you did, you would find some of the tables from it in the back of the presentation that I've made that will show you the percentage of hospital lab tests in millions to private labs, the total laboratory costs and the average cost per test.

1350

You'll notice that the average cost per test in table 3 at the back is always less in the hospital than it is in the private lab. Again, I can point out that the 400 tests that the hospitals have to incur to provide good health care are not being performed by private labs because they're too costly. We're talking about things such as the dexamethasone suppression test, which is an expensive test that a public lab would not even look at.

Mr Clement: That's a fair point. I guess it depends what you include as costs. It doesn't happen all the time, but sometimes when you exclude certain items as part of your operational costs, you can really look like you're doing something quite efficiently. Sometimes you're excluding costs which are part of your overhead, but you're shifting them to other things. I'm not saying that's what hospitals are doing. All I'm saying is I'd really like to see what his basis was for making that conclusion in terms of the overhead costs and who pays for those.

Maybe it's not opportune for us to discuss it, because I haven't read the report, and I acknowledge that, but I am quite looking forward to reading it.

Mr Heath: I would advise you as well that the Dynacare Canadian operation is a very, very small percentage of Dynacare's overall worldwide holdings. They are a multiconglomerate. They are based in the United States, and profits from Canada, even though they may be employing a few people in your riding, have unemployed a number of people across Ontario. This money is going to the United States.

Mr Clement: I'm sure you didn't mean that as being offensive, but thank you for your comments.

Mrs McLeod: I will take just a moment to once again set the record straight as Mr Clement attempts to revise history in the course of explaining how we happen to be in Timmins today. I think even Mr Clement would have to admit that even if the government had been able to persuade us to accept the rather sham hearings of a week before Christmas, those hearings would have been held entirely in Toronto and we would not have had an opportunity to be here today in Timmins in order to hear your presentation.

I was interested in the fact that Mr Clement himself, a little bit earlier in the day, before lunch, said that they weren't prepared to table government amendments until they had heard from people across northern Ontario

because they were so anxious to hear from people in the north. So I think he should surely share our pleasure that the government's original proposal for hearings was not accepted.

I would like to pick up on a couple of parts of your brief which I appreciate. I don't have a page number, but you've said the concern about essentially the minister determining what health care is going to be provided and where it's going to be provided and the unilateral power he will have to do that—you say, "This constitutes a serious threat to our hospital and the people of our district in that excessive travel will limit access to treatment within our area."

I put that together with an earlier statement you made about the Minister of Health having already "recently instructed local planning bodies to submit their restructuring plans now, with or without consulting the stakeholders."

I guess I'd like to ask you what some of your concerns are when you make that statement that there's a real threat here to northerners and their ability to access health care because of the distances. Are you concerned about greater centralization, that closure decisions in the name of funding dollars are going to lead to centralized health care in a community like Timmins or Sudbury, where we potentially can offer different levels of health care, but that there could be nothing left, even emergency care, in smaller communities?

Mr Heath: Yes. We have had that happen already. I can quote a specific situation where a young individual broke his leg in two different places last winter. He was brought to the Timmins and District Hospital emergency room. No orthopaedic surgeons were available; both of them were on holidays. He was to be shipped by air ambulance to Sudbury. Unfortunately, we were snowed in. This individual waited for four days in Timmins before he was able to get treatment. That's one aspect.

Another aspect that concerns me is the fact that specialists can be legislated to certain hospitals. Certain procedures can be specific to certain hospitals. With the powers this bill gives the minister, he can come to a hospital and say: "You no longer are going to be able to do an obstetric procedure. It is going to be done at this central hospital located in Sudbury." We may have been doing it for years and all of a sudden we can't do it. Our patients now have to get to Sudbury in a snowstorm or be denied that treatment?

I think the powers that are being given to the minister are so broad in this bill that it actually sets the way for a total dismantling of our health care system.

There were comments previously of a two-tiered health system. I can see that happening right now. The first thing I think of is the sale of Blue Cross to Liberty Life, an American-based corporation. I can see them trying to buy the WCB here in Ontario. It is paving the way for privatization, and I really feel that health care is one of the sacred things that we have. We have the best system in the world, and to change it this dramatically is going to be a detriment to us.

Mrs McLeod: I want to keep even a little more focused on closure decisions and the rationalizing of health care. I think everybody around this table, and I'm

sure everybody in this room, would agree that we have to look at the most cost-effective way of providing health care services. Government members will say nothing has happened in however many years they like to use—it tends to be 10—and therefore they've got to step in and make the decisions for northern communities and for other communities.

I'm concerned about your statement here that the Minister of Health is already saying, "Submit your plans without further consultation with stakeholders." We've got a lot of northerners here and our experience has always been that Queen's Park, with due respect to the Ministry of Health working out of Queen's Park, does not always have a good sense of northern reality, so the decisions they make on our behalf aren't always what's in the best interests of our communities.

I'm asking you a leading question, so I'll acknowledge it. Do you not think that in smaller communities we can come together and we can determine what is the best for people in our communities and still do that in a cost-effective way?

Mr Heath: I certainly do. One of the items I can think of that has been in the news recently is when the Minister of Transportation was asked to come to northern Ontario to view the roads, to see the conditions that existed in northern Ontario, and said, "I don't need to go up there and look at it." I think that type of attitude is what happens.

By the way, the first snowstorm of this season, my wife's cousin was killed in a car accident because there were two plows sitting in a yard with no drivers.

Mr Len Wood: Just pick up a cell phone; everything will be all right.

Mr Heath: Mr Wood knows this person because they were from his riding.

The Chair: Thank you, sir, for your presentation. We appreciate your interest in our process.

CANADIAN UNION OF PUBLIC EMPLOYEES LOCAL 1214

The Chair: The next group is the Canadian Union of Public Employees, Local 1214. Good afternoon and welcome to our committee. You have a half-hour to use as you see fit. Any time you leave for questions will begin with the government. The floor is yours.

Ms Nichole Daggett: Good afternoon. My name is Nichole Daggett and I have been working in the health field for the past 20 years.

This morning you heard Sister Brenda Cooper from a sister local speak on certain sections of Bill 26. I will now speak on other sections of Bill 26 which I feel will cause massive deterioration of the public services which took generations to build.

Changes to the Independent Health Facilities Act essentially eliminate tendering processes by giving the minister the authority to request proposals from specific individuals for the establishment of a private health facility. As a criterion for selecting the provider, he can examine the availability of public funding to pay for the establishment and operation of such a facility. The new legislation will expand the power of the minister to bring

new types of health services or facilities under the act and will also eliminate the requirement that preference in the tendering process be given to non-profit Canadian operators.

These changes will allow the Minister of Health to handpick corporations or individuals to open up shop, even open franchises of health care clinics that charge people money. In tandem with the massive cuts being proposed to hospital services, it seems clear that this new legislation will allow health care gaps to be filled by more private clinics or organizations intent on making profits off public funds.

1400

To date, the Health Insurance Act has required that OHIP cover all medically necessary services provided by physicians. The bill removes any references to medically necessary services and instead authorizes the cabinet to decide which services will be insured and under whatever limitations or conditions. Cabinet is also given the power to determine that certain services will not be insured unless they are provided in or by designated hospitals or facilities. The only restriction is that no regulation may contradict the Canada Health Act.

These provisions will, it seems likely, be used to limit access to services which are now provided under the Health Insurance Act. The government can decide, at will, what types of care are medically necessary and what are not. The potential for abuse is enormous and certain services which are currently covered under OHIP could be delisted simply because the government decides that they are too expensive.

While hospitals are presently permitted to charge patients for a limited range of insured services, the bill will provide explicit authority for cabinet to make regulations which could permit hospitals to charge patients user fees for any hospital-based insured services, including those already covered by OHIP.

As an example of this, the government has already announced that hospitals will be able to charge daily user fees to those patients in acute care beds who are waiting placement in chronic care facilities or nursing homes. Patients will essentially be penalized because they have been placed on a waiting list for services that are already critically underfunded.

With this new legislation, the Tories are encouraging hospitals to offset their budget reductions by charging user fees and even allowing them to make a profit at the expense of patients. Again, decisions regarding the delivery of health care are not based on access and quality of services but on financial considerations and on the desire to privatize Ontario's medicare system.

The Ontario drug benefit plan provides payment for prescription drugs to seniors and those on welfare. Should schedule G be enacted, the legislation will have dramatic impacts on low-income persons and seniors. Bill 26 brings in a \$2 copayment for all prescriptions under the Ontario drug benefit plan. This is especially hard on the many mother-led families of disabled children, who already have had their social assistance benefits cut by almost 22%.

In addition to the already deep cuts in income to the poor, the government is proposing increases to the cost of

their medical care. The ability to pay for prescription drugs for sick children and seniors should not be an issue for residents of Ontario. The bill would put a two-tier health system in place. If the bill passes, a user fee for prescription drugs could be introduced. This, along with the proposed \$100 deductible, for the poor will mean large numbers of the sick will be unable to afford treatment.

As with other sections of the bill, the minister and the cabinet will have full power to establish and set, behind closed doors, the level of user fees or copayments under the Ontario Drug Benefit Act.

In addition, the current law requires that individuals be reimbursed for the full cost of their drugs when their doctor has specified that no substitutions to the prescription be allowed. The proposed bill, however, requires the individual to pay the difference between the generic and the specific drug. Typically, for example, the doctor specifies no substitution for medical reasons when the generic would interfere with other medication or allergies.

Negotiations will be replaced by cabinet decree. The government intends to terminate the negotiation process with the pharmacists whereby the professional fee for dispensing drugs is typically negotiated between the government and the pharmacists' association.

Cabinet will then act as pharmacists. The bill will give cabinet decision-making authority over which drugs are eligible to receive reimbursement under the plan, again with no need for public process or rationale. The schedule suggests that cabinet will be authorized to consider any matter it considers advisable in the public interest, including the cost of the drug, in determining whether or not to list a drug. The interference in the medical process by government is astounding. Medical necessity or other health criteria do not necessarily have to be considered. Cost will be the criterion.

Interestingly, however, the schedule would allow the cabinet to establish clinical criteria for the purpose of determining what drugs the benefit plan will cover.

The bill will repeal the power of the minister to regulate the price of drugs charged to anyone not covered under the Ontario drug benefit plan. Manufacturers are thus freed to independently determine the price for their drugs other than those provided under the drug benefit plan. We can speculate that the price of drugs will increase, particularly in small communities where little or no competition exists. Without regulation, we can expect that the cost of drugs will increase substantially.

Increased drug costs will severely impact upon CUPE members' group benefit packages. We are already feeling the crunch at the bargaining table because of the increased costs for extended health care due to the increase in the price of drugs. The bill will exacerbate this problem.

Clearly, the government is putting itself above the law. The bill will reverse and nullify certain court decisions which found that the Minister of Health acted without jurisdiction in limiting the price for certain listed drugs.

Not only does the legislation remove any public process for setting prices of drugs and determining issues under the Ontario drug benefit plan, but it is reversing court decisions that went against past government deci-

sions. Why should Ontario be the only province in Canada that does not have a ceiling on drug prices?

Schedule G will hurt seniors and low-income citizens in the province. Drugs prescribed by licensed doctors and dispensed by licensed pharmacists must be covered by the Ontario drug plan. Not only must they be covered; they must be affordable to low-wage workers. Otherwise, we are placing the health of low-wage workers even more seriously at risk. That means people will be forced to shop around for the best price on their prescriptions.

Even though this sounds simple enough for us to do, many low-income families do not have the luxury of having their own transportation and must depend on public transit systems. But this government has taken care of that too. By cutting transfer payments, we are seeing our transit routes being reduced. So shopping around for lower drug prices could cause these low-wage workers or welfare recipients further hardship.

1410

As workers in the health care field, most of us fall under "essential services" and are denied the right to strike by government, yet this same government is now saying these "essential services" are not that important and can be downgraded to the point that people under our care are being seriously affected.

As an employee of the health care system, I have witnessed first hand the cuts to health care which have already taken place. For example, in order to cut costs at my health care institution, the residents are now being given one bath per week. Would you consider this to be quality care for seniors? Would any of you be willing to take one bath per week? How healthy could this be? I am ashamed to call myself a caregiver when I am forced to carry out such directives for the sake of cutting costs. The fact that this government would consider further cuts to health care at the expense of the sick is totally appalling and unacceptable.

I am a member of the Canadian Union of Public Employees, and like all my brothers and sisters in the labour movement, I say scrap this omnibus bill which will destroy local democratic institutions, devastate public services and impose hardship on Ontarians, especially those who are most disadvantaged.

The Chair: Thank you. We've left about 15 minutes for questions, to begin with the government. Mrs Ecker.

Mrs Ecker: Thank you very much, Ms Daggett, for taking the time this afternoon to bring forward your views and concerns about the legislation. One point you do make about the no-substitution rule—I share that concern. I think that's something I certainly would like to suggest to the Minister of Health, that we may want to take a look at that and see if there's another way to do that, because I quite understand that there are times when there are differences in the drugs that are very, very important, and I think that's a very good point.

You mentioned that the legislation removes any public process for setting the prices of drugs. What's the public process for setting the price of drugs now?

Ms Daggett: For setting the price of drugs, yes, it's regulated.

Mrs Ecker: I wasn't aware there was a public process for setting the price of drugs. That's why I just wanted to

clarify that, because I wanted to make sure I didn't miss anything here, since you had said that the legislation removed it.

The second thing, you talked about "Drugs prescribed by licensed doctors and dispensed by licensed pharmacists must be covered by the Ontario drug plan." Are you saying that we should be expanding the drug plan, we should be spending more money on it?

Ms Daggett: What I'm saying is not expanding it, but whatever the situation is now, I'm seeing that some of the senior people won't be able to afford some of these drugs.

Mrs Ecker: Well, they don't have to pay for the cost of the drug. One of the things we've tried to do with the changes is to also extend drug benefits for 140,000 low-income people, because I agree that there are many working people who do not have the benefit of an employer drug plan and need the support. So that's one thing we have been able to do.

One of the other things, you were concerned about the power that the minister and the government are giving themselves in this. You quite rightly point out, and our colleagues across the way quite frequently point out, that the north has unique health needs, which I certainly understand all too well. How do you suggest that the government should try and reallocate the health care resource, for example, go to communities, say, in the southern part that may have excess health care resources and convince them to give them up so that the minister can reinvest them here for very good purposes up here? How does the minister do that without some legislative power in order to do that?

Ms Daggett: I think some of the ministers should maybe come and talk to the workers and listen to the workers, listen to the people; they know what's best for our region or our small communities. Listen to them.

Mrs Ecker: I know you're quite right that there are unique needs in the north. We've had many people talk about the problems that have existed to date in northern health care, and we all agree that we have to do more to improve that. How does the Minister of Health go to the communities in other areas of the province, the other workers, and say, "I want to take that money away from you to give to the north, because we know we haven't got new money in the system"? How does the minister do that, answer the concerns that you've pointed out here in the north, without some power to be able to do that?

Ms Daggett: Well, I'm not quite sure how the minister would do that, but I think it should be done more democratically, have a voice. Everybody should have a voice in how you're going to be doing it, not just say, "Well, this is how we're going to be doing it."

Mrs Ecker: One of the things that I think the minister has been very clear about is that the local planning process, the district health council planning process, which many areas started under the previous government, many areas are now just starting, will be the recommendations that we will be basing restructuring on, because it's the local communities that will have those recommendations and that expertise for the restructuring commission. The difficulty, of course, has been that when the district health councils have made and are making the

recommendations we've had no mechanism to start making that change happen. So that's one of the reasons why we needed the changes.

Mrs McLeod: Mr Chairman, I actually feel a moment of hope that we're making some progress when I hear Mrs Ecker say that the government—at least she, as a government member—would like to encourage the minister to look at the no-substitution rule. Since before Christmas we were being assured that there was no problem with the no-substitution issue, I feel as though maybe we are making some progress, and that is encouraging.

I did think that your presentation on the whole question of the affordability of drugs was very clear and that you were raising two very separate issues; one was the copayment cost and what that would mean for welfare recipients and seniors who are on the drug benefit plan and will now have to pick up that copayment. The other point I thought you were raising very fairly was for those who aren't on the drug benefit plan but are still low-income people, and there are lots of those out in our communities, that they're going to have to, as the minister said, barter for the best drug price. I was raising the point earlier that in a small northern community there isn't likely to be an opportunity to even barter, because there won't be more than one outlet. So I thought your point was made very clearly.

The other point, among others, that I was struck with in your presentation was the statement that the only restriction on the government's ability to decide what will be considered medically necessary is the Canada Health Act. I should tell you that there is a very large question about this entire portion of the bill, as to whether or not the whole thing contravenes the Canada Health Act. I find it a little bit alarming that any government would propose such sweeping changes in government decision-making powers on health care without having determined whether in fact it can do any of this without being in violation of the Canada Health Act. I hope we get a clarification on that very quickly, before this province faces a very severe concern with the way in which we get funded for health care.

I have a couple of things that I wanted to ask you. It follows up on the previous questions. I guess one of the points where I get a little bit alarmed, because I'm a very strong believer in regional planning, is when I hear the government say that the district health councils' existing consultations will be the basis of them stepping in and deciding to take immediate action, and other presenters have said that.

I'm not sure that in every community the district health council consultations have been seen to be very satisfactory. There are a lot of stakeholders who feel as though they weren't involved. I can't judge in this particular district, but I've heard that in other districts. In fact, I've heard the current Minister of Health when he was the Health critic be very critical of some of the district health councils and the work that they had done. So I'm a bit surprised that he is now going to take all of those existing studies and use those as a basis to just say, "We want this done, and we want it done tomorrow."

Do you think that as front-line health care workers you can be involved in a real consultation that will lead to

savings and more cost-efficiencies in the way health care is delivered in this area?

Ms Daggett: I think we should be more involved; I don't think we are right now. Everything is being decided and nobody is asking for our input. I don't know. I'd like to have more input to try and work together instead of having just one or two people deciding how it's going to affect everybody in our area.

Mrs McLeod: You're in a long-term care facility, I would suspect?

Ms Daggett: Yes.

Mrs McLeod: I was alarmed by the statement you made about residents only getting one bath per week, which is obviously a very great concern. But have people in the long-term care facilities been involved in any of the consultations about the future of health care in the region?

Ms Daggett: No, not in my facility. I couldn't say about others, but in my facility we weren't approached.

Mrs McLeod: That's fine.

1420

Mr Len Wood: Thank you very much, Nichole, for bringing forth an excellent presentation. I found interesting the question that was put to you by Janet Ecker.

Our concern is the reverse. She's talking about bringing southern Ontario health care dollars up to the north, and in effect what is happening is the Tories are taking health care dollars out of the north to supplement southern Ontario, and I think it's very unfair. We have the harsh climate, we have the long distances between communities and yet right now, as we're sitting here, when she's saying that they want to bring health care dollars from southern Ontario to the north, they're actually taking health care dollars out of Cochrane North so that they can move them into Stoney Creek. They're also trying to shut down a long-term care facility in Hearst. Cochrane and Hearst are both being attacked so that they can spend those extra dollars in southern Ontario.

I think it's very nasty on their part and uncalled for and they should be apologizing to the people in northern Ontario. We're being attacked, as far as the condition of the roads is concerned, for winter snowplowing. They're shutting down the airline service. They're taking health care dollars out. Every time you turn around they're being attacked on it.

I find it interesting, on page 7, where you're saying that the seniors and the poor and the people living on fixed incomes are not going to be able to afford the money for prescription drugs, whether it's a prescription dispensing fee of \$6.11 or the \$2 per prescription that they have to pay the druggist. In the event that they are not able to buy this, I would presume that they're going to end up in the hospital, and health care costs are going to increase.

Ms Daggett: Yes.

Mr Bisson: I sit here like Mrs McLeod, a little bit in amazement as I'm listening to the government members. I think they are having a change of heart. I think they may be starting to listen, and I hope that's what they're doing, to some of the submissions here because they're starting to recognize just how flawed this legislation is. What particularly amazed me was the comment made by

the government member that she wasn't aware of what was happening in the act in regard to drug prices. I just want to quote directly from the act here.

There are two important things that are happening in regard to medication that is dispensed in the province of Ontario.

The first is that the scheme for determining the price the minister pays for drug product is changed. The concept of best available price is eliminated. Instead, the price will be agreed to by the manufacturers.

What that means to say is that we, as purchasers through the Ontario Trillium drug program or through the Ontario drug benefit program, are not going to go by the best possible price; we'll go by whatever the market can get out of us, which means to say that we, the consumers paying those tax dollars to help to pay for the medication of people in institutions and people on benefits, over the long run are going to end up paying more. So it's quite contrary to what you're trying to do.

The second thing that it does, and again I quote directly from the act, is that the restrictions on the markup the minister pays on the drug prices are removed. Presently in Canada, every province regulates the amount of money that we pay for medication as we buy it from the pharmacist down the street. In other words, the pharmacist and the person who manufactures the drug can't raise drug prices more than a certain level, as prescribed under legislation. What this act does is to open that right up and it says basically that the manufacturers and the pharmacists can charge what they want. I don't know, but I think we're going to be put in a little bit of danger.

I guess it comes back to a question that was asked earlier. I got a call from the executive director of one of the long-term care facilities here in Timmins who was really concerned, followed by phone calls by residents who were making exactly that point, that the comfort allowance people are getting in institutions is barely enough as it is now. I know I was lobbied, when I was government, to have them increased to be able to deal with basic necessities, and what they're really worried about and what senior residents are worried about in these facilities is, "If it's a choice between getting my hair done, of being able to buy my toothpaste or being able to buy whatever type of sanitary product I need or being able to purchase drugs"—in some cases they're not going to purchase the drugs. I think we're putting seniors at risk in those institutions. I certainly hope the government is hearing that message and is prepared to make amendments along that line.

The question I have for you is, and it was touched on in your presentation and the one before—there is a recurring theme inside this act. What it basically does is it changes a number of acts in order to give the minister the power to reduce the amount of funding to public facilities, and therefore the public facilities don't have the bucks to make them operate and they will offer substandard services in order to cope with the budget reductions. At the same time, they're giving the private sector the ability to move in and set up facilities in competition with the public sector.

Do you see that, in the long term, as being something that will set up a two-tiered health care system in Ontario and what it means to people of the north?

Ms Daggett: Yes, I see that. Will it be quality care that these people are going to be getting, these seniors?

Mr Len Wood: Only if you can make a profit.

The Chair: Thank you for your presentation. We appreciate your interest in our committee process.

PATIENT ACTION

The Chair: Next is Patient Action, represented by Ginette Lafond, the founder and executive director. Good afternoon and welcome to our committee. You have a half-hour to use as you see fit. Questions will begin with the Liberals, should you allow any time for them. The floor is yours.

M^{me} Ginette Lafond : Bonjour. Bienvenue à Timmins. Bonne année. Je suis ici aujourd'hui pour exprimer mes commentaires au sujet du projet de loi 26.

The Chair: Excuse me for a second. Would give us few minutes to put the translators on?

Ms Lafond: If I'm going rely on a translator, I might as well do my own in English.

The Chair: It's your choice.

Ms Lafond: I'll do it in English to get the message across. I feel I'm the best person to do it.

The Chair: Okay. Proceed.

Ms Lafond: I've got everything in French, so I have to translate real quick.

First of all, I have important questions for the committee before I give my presentation. I'd like to know what the committee's mandate is, Mr Chair.

The Chair: The committee's mandate is to have public input on Bill 26.

Ms Lafond: What are your powers?

The Chair: Our powers are to listen to the public input, to go through the bill clause-by-clause the week of January 22, to entertain any amendments and to report the bill back to the Legislature on January 29.

Ms Lafond: Will you be submitting recommendations?

The Chair: It's too early to tell yet. We haven't heard all the input yet.

Ms Lafond: The reason why I'm asking this is, I'm wondering, are all the presenters here today wasting their time or will their suggestions be taken into consideration?

The Chair: Every submission that the committee receives, be it a verbal presentation like yours or a written submission by people who haven't had an opportunity to present verbally, will be considered by all the people who are part of the committee and will be discussed during the clause-by-clause part of the bill, which is the week of January 22. So in my opinion you're not wasting your time.

Ms Lafond: Okay, in that case I will proceed.

This morning I picked up a copy of the 1995 Fiscal and Economic Statement by Ernie Eves, and in the introduction it states, "We have listened—and will continue to listen." Why, then, has the government decided to send the committee after the execution of cutbacks and not prior to?

If the government really listened to Ontarians, sessions such as these would be extended over a period of time much more extensive than what it is now. Six hours in

the region of Timmins to discuss vital services which represent a very large geographic area—as a matter of fact, according to the road atlas, the Timmins area is more extended than any other areas in North America. So six hours to make a decision on what will happen to the north is very hard for me to digest today.

1430

I will, however, represent vulnerable northern Ontario patients today. I will present cases. The reason why I decided to present cases is because I wish to let the government know that in northern Ontario we have real people and we are also human beings. We all have a face, a body, we live our emotions, we have no money, and the government wishes to remove the only things that keep us together right now: our dignity and our humour. Where will they go? What will you do for them?

Case number one: An invalid, 75 years old, must take a variety of medications for a variety of medical problems. He also has to travel to obtain vital services for his survival. He lives in a very small town. He must go to North Bay, Timmins or Sudbury to obtain specialized treatments. His pharmacy, his family doctor and hospital are a 20-minute drive from his house. He has no family. He has no car. The only mode of transportation for him is Ontario Northland which, for now at least, passes once in the morning, and he must return at night. So for any business he has to do for medical reasons he must go out of his community, 20 minutes away by car, and he must stay there all day, including eating his meals.

The Harris government wants to deregulate pharmaceutical services and medication. It states in here that the patients will have to pay \$100 a year plus the cost of dispensing for every medication. Imagine this gentleman who has to travel to seek medical help; or even if he needs to replenish his medication, he either has to go or have a taxi pick up his medication. That means this widower must pay dearly, sometimes double and more, more so than the patients in metropolitan areas.

The travel grants have also been cut, and he realizes that the so-called specialists the government is trying to push on our area will definitely never go into his little community; they will go to places like Timmins, Sudbury and North Bay, the same as they do now. They will definitely not go in an area where there are no hospitals, so he'll still need to travel his 20-minute drive. He is poor. He is alone. What will the government do for him?

Case number two: A young patient has been sexually assaulted by a so-called health professional. After many years of counselling, the patient feels courageous enough to start legal proceedings. The defence lawyer wishes to see her mental health file. Nowadays, at least for now, the Supreme Court of Canada has judgements against the delivery of such services.

Bill 26 gives a blank cheque to the commission to obtain any medical file and also to do whatever it chooses to do. Also, no one will have the choice, no one will be able to sue the government, because according to subsection 8(9) there is complete immunity. I can read this. It says, "No proceeding for damages or otherwise shall be commenced against the commission or against a member, officer, employee or agent of the commission for any act done in good faith"—by whose standards I'm

not sure—"in the execution or intended execution of any its or their powers or duties or for any alleged neglect or default in the execution in good faith of any of its or their powers or duties."

Now, that scares me. That means the government now will be able to walk in, obtain medical files not only describing the physical condition, the mental condition, but they now are also taking the patient's soul. Where is the justice? Who will be responsible for the suicide that will follow?

Case number three is a young quadriplegic. She worked, then she went for a treatment and something happened during that treatment. She is now a quadriplegic. She needs 24-hour service. The nurses are with her at all times. However, because of cutbacks in the small areas—again we're dealing with a very small area—registered nurses are now leaving the area because they've been laid off. Because her situation is too complicated for nursing services, consequently, on December 26 of last year she was sent forward to Sudbury and she is now in an intensive care area in Sudbury area.

This patient is not sick. She is a quadriplegic, she's on respirators, tracheotomy, the whole ball of wax, but she's not sick. The local area hospitals could not accommodate her, again because of budget cuts not being able to expand the service for her. Here she is, stuck in an area of intensive care. I know; I saw her last weekend. Here she is stuck in an area of intensive care, not in the same area as the others because she's not sick and she also does not wish to see what goes on in the rest of the ICU. If any of you have been to an ICU area, you will know what I mean. It's an open complex.

Her only social life right now is a TV. Then the medical staff wonder: "How come she's depressed? We don't understand it." What will the government do about her?

1440

Case number four: A northern Ontario baby had a heart transplant at the age of seven months. Getting a heart transplant is not the end. That patient must stay in Toronto for months. Once in a while she's allowed to come home in her remote area. The government, as of November 30, has cancelled the multipatient transport unit. There are no more.

How is this patient going to be transported? I suppose she could rely on norOntair for this week, and they're shutting it down. So now, in order to transfer this little girl, they will have to admit this little girl into the hospital overnight in order to get a dedicated aircraft, because the multipatient transport unit is no longer around. What will the mother and the child do? Does the Harris government have solutions for that one?

Case number five: A young man from the Sudbury area has a heart condition. You say, "But there is a heart hospital in Sudbury." Wrong. The heart hospital in Sudbury cannot accommodate him. He must be transported to the research centre at Mount Sinai because of the condition of his heart. He is not allowed to drive. We tried to transport him in a private car. We also tried to transport him by bus. Upon arrival, he suffered heart attacks because of exhaustion from the trip. And that's only from Sudbury; he's not even in Timmins yet. He's

not allowed to take a commercial aircraft, again because of his heart condition. Will the Harris government send a private jet for this gentleman?

I could go on all day giving you case after case. I could spend the whole afternoon, but we only have six hours today and I'm not the only presenter. I'm just hoping the Harris government will listen to the dilemmas and realize that there are true human beings up north. Thank you.

The Chair: Thank you. We've got about four minutes per party for questions, beginning with the Liberals. Mr Brown, I guess you're carrying the flag here.

Mr Michael Brown: Thank you for presenting. I think you brought to us a very important perspective that, up to this point today anyway, we have not heard from. Health care is about people and it's about patients, and the examples you've given us today illustrate the difficulty we have in northern Ontario. I represent the riding of Algoma-Manitoulin, where a large section of the riding is what you would call very rural and very northern.

One of the things our friends from southern Ontario don't quite understand is that although we're maybe 8% or 9% of the population of this province, 75% of us live in one of the five major centres. So we've got about 2% of the people in this province spread out across 90% of the land mass. That is critical to us in terms of providing health care. It makes it enormously difficult, I think, for providers, but it has to be done because there are real people out here.

I think the examples you're giving drive that home. Losing our air service to the communities that now have it will have a definite effect on the people I represent and certainly the people in this area; losing the ability for certain things—to be able to go to a nearby hospital, even if it is Timmins, if you happen to live 50 miles from here, or North Bay, if you're 25 minutes from there—if we lose some of those services, which this bill quite clearly, at least in my mind, is going to facilitate from the government's point of view.

When I sit here and I listen to what the government's saying over there, I think we all should think of it from the patient's perspective. Are we going to get more health care or better health care, improved health care, or are we going to get less health care and quality care deteriorating in this province?

I sit here and I understand that we're going to pay more for health care. We are. There are user fees. I think we've only scratched the surface on what user fees are about to appear. We know people on low incomes on the Ontario drug benefit plan are going to be paying increased amounts of money. The government is clearly taxing health care, taxing the sick, taxing those who are least able to access the system as it is, yet they're going to provide us with less services. I don't see how you can come to any other conclusion.

Is that what you're telling me here today? Because I think those problems you've related to me in terms of patients are similar to problems that I've dealt with in my constituency office.

Ms Lafond: Absolutely. My office has only been in operation since September 1995 and I am overwhelmed. We were seriously considering hiring, because I must

spend so much time with the patient service that I don't have time for the administration. It's unbelievable, and this I did for three years on my own.

Ms Lankin: The concerns you've raised are concerns that we've heard from a number of presenters today about how this bill centralizes decision-making power in the hands of a few, perhaps senior, bureaucrats and the minister down at Queen's Park and that decisions made in Toronto aren't going to be in the best interests of the north. The lack of understanding and the history that people have had—I mean, you just know that and you've driven that home in a very, very powerful way, and I thank you so much for your presentation.

Some of the things you touched on, the government keeps saying: "Not to worry. It's not a problem." Like the concern about privacy of health records. They say nothing's really changed here. You've raised concerns. I say, if nothing's changed, then why are they amending the act in that provision?

They say the appointment of supervisors to a hospital is so rarely used, even though they're giving themselves more power to do that now unilaterally, and the Health minister told us he probably would never use it. Why are they changing the legislation then?

The section that allows them to say certain OHIP-insured services would be prescribed for only people of certain ages and not other ages, they say that was there before and it's just moved and nothing's different. Why are they tampering with it then and why are they moving it? We haven't had any answers to this.

They say they don't want to Americanize the health care system, but they're removing the Canadian not-for-profit preference in independent health facilities. Why are they removing it, if not to open the door for Americans or others to come in?

They say that they're not going to move to a two-tier health system, yet they're removing protections of the Canada Health Act language that's in certain parts of the bill governing certain things that they're moving out from underneath that protection.

I've got a letter a doctor sent to his MPP, who happens to be the Honourable Bill Saunderson, the Minister of Economic Development and Trade. He references the fact that Mr Saunderson is a member of the policy and priorities board of cabinet, the inner cabinet. This scares me, and I just want to leave you with this to think about, because I think it will upset you too. He relates what the doctor and this powerful cabinet minister talked about.

"You indicated that deductibles for drugs were being discussed and that might be extended also to apply to physicians' services in some form of deductible or user fee." This is the writer saying Mr Saunderson indicated that. "We've discussed that the idea of a two-tier system was abhorrent to certain left-leaning sectors of society and the media, but we did agree that it already exists de facto."

He goes on to talk about: "You indicated that relief was around the corner in the form of decreased personal taxes. But we then talked about the abolition of the employer health tax and perhaps the reinstatement of OHIP premiums. We also discussed the development of

a list of core services that are fully funded by government, others not being fully"—in other words, delisting.

"We briefly touched on the role of the federal government decreasing transfers but their wish to maintain control. This will have to be addressed, and legislative barriers to private insurance as an alternative form of health care funding must be examined." These are the things that a member of the inner cabinet of the Harris government is talking about with this particular physician, who documents it all in a letter back to him.

I worry about paving the way for a two-tier system, and I think I heard you talk about that as well.

Ms Lafond: There's not only the two-tier system, but all these private insurers will also have access to our medical file, because they can do whatever they want with it.

1450

Mrs Johns: I just have a few comments. I'd like to thank you for your presentation. It's always interesting and teaches us a lot when we hear about specific individuals, and I appreciate that. I just want to comment about what will happen for some of those people.

But I want to say first that we believe we are listening. We believe we're taking documentation back to Toronto, and we will be looking at all the transcripts from every day and searching through them to see what's good and what's bad about the bill. We believe we will be making changes that people ask for. We believe this is a listening process, and I just wanted to verify that with you.

We talked about personal records a number of times today. It was our intent at the time we put the personal record information in that we would be able to use that to track the misuse of billings and inappropriate billings. So if someone billed inappropriately, we would be able to go back and see if the person actually had that service and we could trace that.

We understand, after going through these meetings, that people see more far-reaching issues with it, and we will be making some amendments to hopefully satisfy people. It was never our intent that my health records would become part of your knowledge throughout Ontario. So that's what we're trying to. Do you want to comment on that?

Ms Lafond: Yes, I want to comment on that. First of all, if more of the public would know that everybody has a boss and if you're not satisfied with the service you're getting, there are regulated colleges and regulated professional bodies—however, unfortunately, many of the public do not know this. Now, with the Regulated Health Professions Act, we are getting the word out to the public. There's one way of discovering—uncovering, I should say; not discovering—much of the OHIP fraud.

Another way—I know because it happened in my very own family—some insurance companies are now contacting the insured or the people who have had insured benefits and asking them, "On such-and-such a date, did you see Dr So-and-so and what did he do?" That's happening right now. There are more ways of uncovering professional scams.

Unfortunately, no, we will not be able to get them all. For every three we take, there are another three that are uncovered, because more and more people are getting

wiser and the ethics are now going down. But with the public awareness that has started already, we have to give it a chance. The patient relations committees, the quality assurance committees, are just in the works now. I know. I'm a public appointee and I'm sitting on a quality assurance committee, and that's exactly what we're doing. We're just putting things together, but you have to give us a chance.

Mrs Johns: We agree with that too. There are a number of areas of quality assurance that are in the works and we wanted to make sure that there was enough to take care of consumers' needs. I'm not in any way implying that the doctor is the bad guy in this. I'm not saying that at all. When we look at the total percentage, it's very small in comparison.

We're also doing things for people with spinal injuries. We've brought a lot of them back from the US, as you know, and we will continue to look for new facilities to put those people in. I have heard on all of my long-term-

care meetings that people with spinal injuries are not sick; what they are is not able to take care of themselves in a number of ways and they need special treatment, and we will be working towards that.

I just wanted to say from our side that I'd like to thank everybody who presented here today. We certainly learned a lot and we will be taking a lot of information back. We appreciate everybody's commitment to the process, and I'd like to thank you all very much for helping us out today.

The Chair: Thank you for your presentation. We appreciate your interest in our committee process. Let me add my thanks to the people of the city of Timmins. We've enjoyed being here and hopefully we'll all get a chance to come back some day.

The meeting is adjourned until tomorrow morning at 9 o'clock in Sudbury.

The committee adjourned at 1456.

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

Marchese, Rosario (Fort York ND)

Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Johns, Helen (Huron PC) for Mr Danford

Miclash, Frank (Kenora L) for Mr Sergio

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

Bisson, Gilles (Cochrane South / -Sud ND)

Brown, Michael A. (Algoma-Manitoulin L)

McLeod, Lyn (Fort William L)

Ramsay, David (Timiskaming L)

Wood, Len (Cochrane North / -Nord ND)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Campbell, Elaine, research officer, Legislative Research Service

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**Legislative Assembly
of Ontario**

First Session, 36th Parliament

**Assemblée législative
de l'Ontario**

Première session, 36^e législature

**Official Report
of Debates
(Hansard)**

Tuesday 9 January 1996

**Standing committee on
general government**

Savings and Restructuring Act, 1995

Health issues

Chair: Jack Carroll
Clerk: Tonia Grannum

**Journal
des débats
(Hansard)**

Mardi 9 janvier 1996

**Comité permanent des
affaires gouvernementales**

Loi de 1995 sur les économies
et la restructuration

Questions concernant la santé

Président : Jack Carroll
Greffière : Tonia Grannum

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Tuesday 9 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Mardi 9 janvier 1996

The committee met at 0902 in the Ramada Inn, Sudbury.

SAVINGS AND RESTRUCTURING ACT, 1995
LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Good morning, everyone, and welcome to the hearings on Bill 26 by the standing committee on general government. We are delighted to be in Sudbury this morning to listen to your concerns. Just for the sake of the audience, I will have to explain to you how the process works. Each presenter has a half-hour of time. Any time that they leave for questions is split evenly among the three government parties in rotation. We would be starting this morning with the NDP. I would ask the people in the audience to remember that the dialogue is between the presenters and the committee members and respectfully request that you people in the audience refrain from participating. By the way, we do hold fairly closely to the time line because we're on a fairly tight schedule.

MANITOULIN-SUDBURY
DISTRICT HEALTH COUNCIL

The Chair: Our first group this morning represents the Manitoulin-Sudbury District Health Council: Ken Ferguson, chair; Normand Gauthier, vice-chair; and Bob Knight, executive director. Welcome, gentlemen. We're pleased you're here, and the floor is yours.

Mr Ken Ferguson: Good morning, one and all. Thanks for hearing our comments. We're pleased to be here with you. Thank you for this opportunity.

The Manitoulin-Sudbury District Health Council was formed in 1976. We're 19 volunteers appointed by the Lieutenant Governor to advise the Minister of Health on the health needs of our districts. Recently we have focused on the reform of the long-term care and mental health systems, hospital restructuring and health promotion planning. Last spring we completed a major review of the Sudbury hospital system, and I'm pleased to be able to present council's views on Bill 26 this morning.

First off, the Public Sector Salary Disclosure Act, 1995: It has been said repeatedly in our community that the public sector must be more accountable. Therefore, we support the measures outlined in the Public Sector Salary Disclosure Act, except that the minimum threshold should be \$75,000 and not \$100,000. Also, the salary and benefits should be disclosed for the heads of all organizations funded by government.

Amendments to the Ministry of Health Act: The primary role of the Health Services Restructuring Commission will be the rapid implementation of hospital restructuring. Other duties will likely be assigned. The role of the commission will be to complement the new powers of the Minister of Health.

Generally, we support the establishment of the commission. Implementation of hospital restructuring is chaotic throughout Ontario because the current legislation impedes the sweeping changes that are needed. The creation of the commission has the potential to assist the minister in taking decisive action.

Therefore, we recommend that opportunities be given for input into the regulations, recognizing a rapid turnaround time is needed; that the commission's restructuring be based on planning carried out by the district health councils; that the regulations make it incumbent upon the commission to develop linkages with the DHCs; that at least 25% of the commission members include current or former DHC members; and that a role be defined for the DHCs in advising on the suitability of measures under consideration by the minister and the commission.

The relationship we recommend between the commission and the DHCs is based on our belief that the DHCs offer the best advice available on reform of the health system at the local level. DHCs, largely through the input of consumers and the broader public, advise from a position of objectivity. They offer a system and a district view in their work—the only local organization with this kind of role. DHCs are capable of making and have the courage to make difficult decisions for improving the quality of life in their communities.

The commission should have as one of its goals the integration of the health system through restructuring. Their decisions and advice to the minister should be based on a consideration of the broad determinants of health espoused by Premier's Councils over the past five years.

Going on to the amendments to the Public Hospitals Act, hospital amalgamations: The amendments refer to the amalgamation of two or more hospitals. We assume this means corporate mergers in one community or in more than one community in a region. This needs to be

clarified, because a hospital is not necessarily a corporation. One corporation may own and operate more than one hospital in more than one community, in which case none of the individual hospitals would be a separate corporation.

The amendments refer to the power of the minister to direct two or more hospitals to amalgamate. Once again, a hospital is not necessarily a corporation. We could use the example of the Sudbury General Hospital, owned and operated by the corporation of the Sisters of St Joseph of Sault Ste Marie. Because the Sudbury General is not a corporation unto itself, it appears that a merger of that hospital with the other hospitals in Sudbury would not be possible, given how Bill 26 is currently worded. We have recommended a form of merger of the Sudbury hospitals. It appears that Bill 26 would entrench restrictions preventing the minister from directing such a merger.

A possible solution would be a section that would enable the minister to direct the severing of a part of a corporation—for example, one hospital—and the subsequent merger of that hospital with other hospital corporations. Another approach would be to add a section enabling the minister to purchase from a hospital corporation part or all of its assets, with the intent of merging such assets with other hospital corporations.

One of our biggest concerns about the amendments concerning the amalgamations is the illusion they create that they will be applied evenly to all hospitals funded by the government under the Public Hospitals Act. Unfortunately, this will not be the case.

The Premier and the minister have assured the Catholic Health Association of Ontario that Catholic and other denominational governing structures and their missions in the health system will continue. There's nothing wrong per se with such assurances. However, no government interpretation has been offered, giving the CHAO the leeway to develop the most restrictive criteria in North America on the interaction of Catholic and other health organizations.

This has upset the balance in the local hospital governance and restructuring discussions province-wide. The playing field is no longer level. In Sudbury, good-faith negotiation of governance and service issues seems impossible among the key players. Favouritism towards one category of organizations is systemic in the restructuring of hospitals.

0910

The Catholic nature of health care organizations can be preserved even where mergers may be directed by the minister. We refer to publications of the Catholic Health Association of the United States. Bill 26 should contain a section making it clear that each and every publicly funded hospital in Ontario, including Catholic and denominational hospitals, may be directed to amalgamate. There should be no policies of the government that offer exemptions to certain classes of hospital organizations.

The minister's powers regarding grants and services: Schedule F empowers the minister to alter hospital funding and the scope of services provided by a hospital. We give qualified support to these measures. They are needed to speed up the restructuring of the hospital system. Our qualifications are as follows: The role of the

commission and its relationship to these powers of the minister must be clearly defined. Where the minister directs such changes, they should be based on what is in the best interest of the communities affected. The minister and the commission should rely on the advice of the public, through their DHCs, in this respect.

Investigators and supervisors: Schedule F refers to the appointment of an investigator. We would recommend that the wording be changed as follows:

"The Lieutenant Governor in Council may appoint one or more persons to investigate and report on the quality of the management and administration of a hospital or group of hospitals...."

Such a change in wording would recognize the relationships and the interdependence between hospitals in multi-hospital communities. Similarly, the amendments concerning the appointment of supervisors should refer to a hospital or a group of hospitals.

Investigators and supervisors should seek advice from the DHCs in determining what may be in the community's best interests. We recommend the following addition to subsection 9.1(1) of the Public Hospitals Act, "(e) the advice of the district health council."

The physician human resource plans required of hospitals should be subject to review by DHCs. The concept of a group of hospitals should be used. Schedule F should contain provisions enabling the minister to prescribe the medical staff organization for a group of hospitals.

Amendments to the Independent Health Facilities Act: The proposed amendments give much broader discretion to the minister in granting independent health facility licences. The granting of licences and approvals for relocation should occur only upon consideration of the needs of the communities affected, with input from the DHCs.

We agree with the Information and Privacy Commissioner that the measures proposed with respect to the collection and disclosure of personal information are sweeping and inappropriate. If the concern is the elimination of fraud, other means should be considered, such as payment methods other than the traditional fee-for-service approach.

Amendments to the act concerning drugs: Studies have shown that extensive overprescribing of drugs to the elderly is a source of health problems for them. Amendments to the legislation should be made, not just to save money, but also to reduce the overprescribing of drugs to our elderly. Copayments will not be effective in this respect.

We support the amendments that would ensure the minister would no longer pay for a more expensive drug when a cheaper alternative is available.

The prescribing of the dispensing fee should enable competition among the pharmacies on the basis of the dispensing fee. What is prescribed in the regulation could be a maximum. If a pharmacy offers a lower fee to the general public, it should also be offered to the government.

There should be measures to ensure that people with chronic illnesses should not have to make frequent visits

to the pharmacy, triggering frequent payment of dispensing fees if frequent visits are not medically necessary.

Amendments to the Health Insurance Act and the Health Care Accessibility Act: The amendments intended to combat fraud and inappropriate use of insured health services are sweeping and inappropriate. We recommend that considerable progress could be made in these areas by the expansion of alternative payment methods for physicians and other practitioners. These approaches would have been much easier to administer. The sweeping measures with respect to personal information would not be needed.

We support in principle the amendments intended to correct the imbalances in geographic distribution of doctors. The measures tend to be negative—for example, the setting of differential fees—and continue to depend upon fee-for-service payment. Once again we recommend the aggressive pursuit of alternative means of paying doctors, for example by fixed-price contracts.

Amendments to the Freedom of Information and Protection of Privacy Act: Out of concern for ensuring accountability of government organizations to the public, we cannot support the proposed amendments to the Freedom of Information and Protection of Privacy Act that would have the effect of restricting access. We refer specifically to the measures eliminating the potential for fee waivers and the lack of definition of the term “frivolous and vexatious.”

We offer qualified support for amendments to other legislation intended to achieve restructuring and savings. Such amendments affect the Municipal Act, the Conservation Authorities Act, the Mining Act, the transportation statutes, and acts administered by the Ministry of Natural Resources. Our qualification stems from our commitment to the broad determinants of health. It should be possible to amend the legislation to achieve these fiscal objectives while ensuring that a healthy physical environment and healthy communities are also achievable.

Thank you for the opportunity to make this presentation this morning. I would be pleased to answer any questions you may have.

The Chair: Thank you. We have about four and a half minutes per party for questions, beginning with the New Democrats.

Ms Shelley Martel (Sudbury East): Thank you to the presenters. Let me ask about the Public Sector Salary Disclosure Act. In your last line you said the salary and benefits should be disclosed for the heads of all organizations funded by the government. I assume you are suggesting that those groups that are for-profit but receive a substantial amount of money from the province, such as nursing homes, should be forced to disclose salary levels of their CEOs as well. As you know, under Bill 26 at this point, they don't have to.

Mr Ferguson: Yes, I would agree with that.

Ms Martel: Let me ask you about the restructuring process. The minister, when he made his comments at the opening of this committee in December, seemed to suggest that part of the reason the Health Services Restructuring Commission was going into effect, that part of the reason for the rather draconian legislation he's going to assume unto himself, is that for some reason or

another there are roadblocks in the current legislation that don't allow restructuring or make it difficult.

You folks have been through a process of restructuring in this community for two and a half years. You came to a consensus recommendation, which was forwarded to the ministry at the end of October, calling for a single governance structure. It would seem to me that the roadblock you've run into is not legislation but the minister himself, who refuses to recognize the consensus you brought forward from the community. I'm wondering whether you'd like to comment on whether any legislation would have been necessary to implement the consensus recommendation you put forward, and whether you have any confidence that a restructuring commission, as it's currently outlined, with no mandate and no powers as yet disclosed, is going to be helpful to you.

Mr Ferguson: Good question. I don't know whether I'm qualified to answer that. I believe part of it could have been accomplished without legislation, but I believe legislation ultimately has to be enabled before amalgamations can be put together if they're not willing to amalgamate.

Ms Martel: Would you say that the change you're really concerned about is that all public institutions are treated the same so that amalgamations can occur?

Mr Ferguson: In our brief, we referred to the imbalance, and I believe that still holds.

0920

Ms Frances Lankin (Beaches-Woodbine): I want to ask you about your references to the hospital restructuring commission. Personally, I don't think it's a necessary thing, but I'm not opposed to it; it can be helpful. What I'm opposed to is the fact that there are no terms of reference, mandate, limits on powers, and no reference to a relationship to local district health councils in their restructuring reports and efforts. Would you support amendments to the legislation that spelled out a set of terms of reference and a relationship, at least, to local DHC reports and recommendations from local communities?

Mr Ferguson: I guess we have to recognize that our government is our ultimate authority in—

Ms Lankin: I think the legislation is.

Mr Ferguson: I'm not into the finer points, I guess. None the less, they have the authority to change the legislation. To put in a great deal of control, protection, would be nice, but is it going to be in the long run?

Ms Lankin: We hope, if we can convince the government members that those are necessary amendments, that we might be able to get that in.

Mr Ferguson: I'm not political on that end.

Mrs Janet Ecker (Durham West): Thank you very much for coming today and for your detailed brief in which there are some excellent suggestions in terms of changes that might improve the legislation. I thank you very much for offering them.

One of the things we've talked about a lot over the last several days of hearings has very much been the relationship between the district health council and the restructuring process. As the minister has pointed out to your group, that is very important, that those district health council recommendations are going to be the basis upon

which restructuring will have to be pursued in the areas. If there's clarification needed in the legislation to ensure that is indeed the case, we've certainly indicated that we'd be quite happy to suggest that to the minister. He is quite clear that district health councils are a very important component of the restructuring we have to do.

One of the questions I wanted to ask about was getting back to the difficulty of attracting physicians to northern communities. As we know, that has been a problem many governments have wrestled with and the problem has been getting worse, not better.

What has been, do you believe, the success this area has had in some areas, in attracting physicians here and keeping them and building various programs? What is it that you think the government needs to do to try and get physicians into underserved areas and keep them there?

Mr Normand Gauthier: It's very easy to answer this one. If the recommendations that were put together by this community in regard to restructuring would enhance the working conditions of physicians, that would be the best tool available to help keep our qualified personnel at home.

Mrs Ecker: What specific working conditions? The minister has talked about various support mechanisms for physicians in outlying areas. What specific suggestions might you have to do that? Is it a question of money, of people coming in to support, of having time for continuing medical education? What do you think is the key component?

Mr Gauthier: The key to this is making working conditions acceptable and livable for the doctors. The ideal would be one plant, one hospital in the area. Then everybody would know where the services are and all the doctors would be there, and they'd know where they'd go to work in the morning, instead of spending a good percentage of their day on the road going to work.

Mrs Lyn McLeod (Leader of the Opposition): There are a number of areas we'd love to have an opportunity to explore with you. I think the issue of recruitment of physicians will come up later in the day, so I'm going to hold on that one. You've raised a number of issues I'd like to have you talk about. I'm going to hold off on them, but just to acknowledge them.

In a number of places in the brief, regarding the steps the government seems to feel will reduce fraud and in terms of utilization of drugs with the copayment plan, the access to medical records and also the intervention of the government in medically insured services, you make several statements about these being sweeping and inappropriate powers, and I would like to give you an opportunity to expand on that.

Having said that, I will come back to the issue of the hospital restructuring commission, because I think this is one area we're going to hear a lot of discussion about as the committee has its hearings. I think I'm interpreting the brief correctly when I hear you say that you think it's important for the minister to have the power to expedite hospital closures, providing they act on the reports of the district health councils. I would therefore assume that if the minister does not act on the views of the district health council, you would feel that was a real violation of the local planning process.

I think we've got a real conundrum here. Whether the minister needs more powers or has the power to close hospitals now, I don't think we need to debate. I personally think he has the power: He controls the dollars. We don't need this legislation to give him the power to step into any community and expedite decisions about hospital closures.

What is at issue is how we ensure there's a good process of community consultation. That's what I'd like to ask you. You've been through a lot in the consultation, as other district health councils have, and I'm wondering whether there were adequate guidelines put in place in terms of what the minister and ministries expected to see. It would have been previous governments, obviously. Should there be guidelines in place?

For example, if at least a two-governance model is one of the criteria for acceptance at the end, should that be established at the beginning? Should there be guidelines for consultation? Do district health councils sometimes feel as though they're out working on their own without enough understanding of where the minister is going to come from? If the minister is now going to come in and say, "Sorry, folks, we don't like the work you've done," you should have had a better understanding of that, more guidelines, from the beginning. Can we have a more collaborative process from the very beginning so we're not in such a conflict position at the end?

Mr Ferguson: Yes and no. There was a great deal of discussion on the parameters and on which way the study of our communities was going to be put in place, governance first, versus restructuring or services first. To get the players all involved, the restructuring, the planning of services, tended to be the only one they could deal with to start with; governance was to be left to the end to tail it off.

Having said that, governance was considered at the outset of the study to be the single most important part of restructuring, to get rid of duplication, to get a system where there was one of each right down the line, from administration to medical staff to nursing staff to administration people, one, one, one, right down the line—most efficient, most effective, everybody knew where they were and what they were doing, no confusion about what hospital they were going to be working in today or tomorrow or the next day. All the efficiencies could be worked through one system. There wouldn't be any competition for any of the projects or services; they'd all fall into place as they were needed and where they were needed, logically and clearly, no debate about it.

However, to get the players all involved, the governance part was left to the end, unfortunately. Yes, there was lots of discussion. Several governments were involved in this study, as you're aware, from start to finish, and God knows how many more before it's completed. Hopefully, it will be shortly.

Mrs McLeod: I look towards the future and the fact that we all know there's going to be restructuring. Every community has been going through that. The minister, for better or for worse, is now going to be a larger player at that table. Should the Ministry of Health be part of that from the very beginning in terms of, "Let's all be work-

ing together, bringing all the stakeholders, deciding in advance where we want this to go?"

Mr Ferguson: I believe they were involved right from the start. To be honest, I wasn't on the health council when this was initiated. I understand several chairs have done studies in years gone by, and those studies sit on the shelf gathering dust. This is the first one that's come as close as it has to finding implementation, and we hope and have faith that it will find resolution in restructuring and come to fruition to serve the community.

The Chair: Thank you. We appreciate your attendance this morning and your interest in our process.

Mr Ferguson: I have one last comment, if I might. One of our facilities in town has been able to get on the floor to speak with you, but one of our hospitals made a request and was unable to. I would like to ask that you reconsider their request for addressing this committee.

The Chair: Unfortunately, we've only left ourselves even a half-hour at lunchtime here in Sudbury, so we have no additional time. But if anybody wishes to present a written brief to us, it will be considered as equally as any oral presentation. So those who did not get on are invited to submit copies of a written brief.

0930

Ms Lankin: Mr Chair, I'd like to place a motion before the committee. It's very apropos in light of the last comment you just made about the hospital that is unable to present here. My motion is as follows:

Whereas there has been overwhelming public interest in Bill 26 and that 50 groups and individuals have requested to appear before the standing committee on general government in Sudbury today, which far exceeds the 13 spaces available today for hearings;

I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, the order with respect to Bill 26 be amended so that the bill can be returned to the standing committee on general government so that further public hearings can be arranged for the community of Sudbury;

Further, that this committee recommends that the three House leaders meet as soon as possible to discuss this issue.

Mr Tony Clement (Brampton South): On a point of order, Mr Chairman: I believe that is substantively the same as the motion that Ms Lankin prepared and that we debated yesterday and that this particular request that is embodied in her motion would have been subsumed into the motion that was defeated by the committee yesterday.

The Chair: The motion basically is in order. I would suggest, out of respect to the people who are here to present, that we use our half-hour lunchtime to talk about it. Do I have unanimous consent for that? Okay, so we'll defer that until 12:30.

SUDBURY DISTRICT PHARMACISTS' ASSOCIATION

The Chair: The next group are the Sudbury District Pharmacists' Association, represented by Norm Grillanda and Claire Shaw. Welcome to our committee. You have a half-hour to use as you see fit. Questions would begin

with the government at the end of your presentation.

Mr Norm Grillanda: Thank you, Mr Chairman. My name is Norm Grillanda and I am the chairperson for the Sudbury District Pharmacists' Association, which I'll refer to as the SDPA. The SDPA represents the pharmacists and 35 pharmacies of the Sudbury region on matters that concern the profession. The SDPA has approximately 70 member pharmacists.

With me today is Claire Shaw, chairperson for the prescription drug plan committee for the SDPA. This committee is quite active in our community as a consulting service for several local employers, and I might add that they include INCO and many of the public sector employee groups. It has been very successful at achieving significant cost savings for these employers in the provision of their employee benefit programs while still maintaining a high quality health program. This is an ongoing partnership and reflects how cooperation between all the parties involved can lead to the control of costs.

Also with us today is Sandi Huty, the district 14 representative for the Ontario Pharmacists' Association, or OPA.

We are very pleased to have been given the opportunity to discuss our views on Bill 26 with this committee. We have attempted to take the approach that we would not offer any criticism unless we felt we had a realistic alternative. We have supported our beliefs with unbiased data and feel that it does merit careful consideration. We have also tried to keep in mind the underlying need to get control of health care spending, which is the primary driving force behind this bill. As front-line providers of this very important service to the ODB recipients in Ontario, we are also very cognizant that the level of care and resulting patient outcome is of primary importance and must never be sacrificed in the name of cost savings.

As background, I would like to give you a little bit of information on what we see has happened with the ODB program.

If we look back at the ODB program, we'll see a record of increases from year to year. There have been many attempts to control these cost increases. These efforts included dispensing fee rollbacks, delisting certain products from the ODB Formulary, such as over-the-counter medications, and finally, an attempt to decrease the number of fees paid by encouraging large-quantity prescribing. I think we will all agree that none of these measures have been very successful, and the ones that did achieve cost savings—for instance, delisting—caused significant financial burden to the ODB recipients.

Costs have continued to increase at rates much higher than the CPI despite all of these measures. This in itself, I would add, has got to be seen as proof that the measures that have been taken so far have not been effective. It also indicates either the government's inability to understand what's causing the cost increases or its inability to deal with them.

We feel that the reasons for the cost increases are very evident when one examines the situation. In Ontario, the percentage of citizens over the age of 65 is rising, and so more people are eligible for the program. The ODB program has recently been expanded to include the working poor and certain segments of the population

through the Trillium program. Although this is quite simplistic, we feel it should be stated here so that there is a more complete understanding of the driving forces. We are in no way suggesting that these criteria are wrong or should be changed in any way.

The ODB Formulary design itself has been responsible for much of the problem. The ODB Formulary has a group of people who make recommendations as to whether a drug should be listed or not, and I'd like to add here that there is only one pharmacist participating on this group. They have attempted to initiate a set of criteria for the selection of various drugs when several choices exist. Unfortunately, for the most part, these criteria are not adhered to for several reasons.

I'd like to point out to you these two government-funded publications that came out last year, one being the anti-infective guidelines and the other being guidelines for the treating of uncomplicated hypertension. These have been put together by experts in the field, and they recommend procedures for prescribing medications for these particular problems. Unfortunately, there's no teeth behind these guidelines and they have not been listened to or adhered to. The results have been an increase in utilization of the newer higher-cost drugs instead of the lower-cost existing therapies.

To substantiate my hypothesis, we cite the Green Shield study which uses Canadian data from 1987 to 1993. Just to give you a little background on what Green Shield is, in 1993, Green Shield processed 3.5 million claims with revenues of \$252 million. The study states that the cost per claim for all prescriptions from 1987 to 1993 rose by 11.6% per year compared to a 3.5% annual rise in the CPI. Green Shield goes further and breaks down the causes for the increase into several reasons:

- 33.9% of the increase was due to the increased cost of existing drugs.

- 15.1% of the increase was due to an increased quantity being prescribed per claim. This is quite interesting also, as you'll see later.

- There's a 4.3% decrease in the cost due to a shift in usage of existing drugs.

- Most notably, I refer you to the last point, which is that 54.6% of the increase was due to a shift towards the use of newer, more costly medication.

Green Shield also reports that there were shifts in prescribing within therapeutic classes of drugs towards higher-cost products and that there was a definite shift towards drugs holding patent protection, which prevents the use of generic alternatives. New drugs made up 49% of claims in 1993, and this compares to 1.5% of claims in 1988, a very substantial increase.

They also go on to compare the average cost of existing therapies—that would be in 1987—that was at \$16.92, versus \$43.24 for new therapies. I'd like to point out that although this data does not include ODB data, the ODB experience would be a very parallel experience. One examines this data in light of the fact that of the 94 drugs given HPB approval in 1994, the Patent Medicine Review Board of Canada stated that only five of these represented a significant breakthrough or offered a substantial improvement over existing therapies.

I'd like to refer at this point to the Pharmaceutical

Manufacturers Association of Canada presentation that was given to this committee in December of last year, where they state that only 23 of their new drugs were included in the ODB Formulary in the period from 1990 to 1993. They imply that that may not be sufficient. In light of the information given by the Patent Medicine Review Board, I would hesitate to say that it's probably more than sufficient.

I know you're all saying that these types of things can't be happening in the ODB program, but let me give you one example, and I hesitated to do this. I don't want to single out any particular manufacturers or any particular drug products, but I could have given many other examples. The reason I chose this one is this particular product was just included in the ODB Formulary within the last few months. The drug in question is clarithromycin, which is an antibiotic in the class of erythromycin. The typical prescription cost for the former is \$44.66 versus \$3.28 for the latter for the standard treatment period.

Number one, why are doctors prescribing clarithromycin in ever-increasing quantities? It's very simple. The manufacturers are promoting the product quite heavily and spending lots of money doing it. They're telling the physicians that the drug is just as good as erythromycin and it's going to cause less stomach irritation. Well, let's look at the facts. Erythromycin can cause stomach irritation in about 10% to 15% of the people who take it, and a smaller percentage than that will have to stop taking the drug because of these problems. This type of problem occurs in 6% of the people with clarithromycin. So there is a small difference; there is a difference and it is significant. However, does that warrant paying for Biaxin for every single patient who needs an erythromycin prescription? I think not. We understand that flexibilities have to be built into the system so that particular circumstances can be dealt with where a patient may need clarithromycin for very legitimate reasons, and we feel that can definitely be worked in.

0940

Before we deal with the actual issues in Bill 26, I'd like to give the Sudbury District Pharmacists' Association position on health care:

- (1) The SDPA believes that all Ontarians should have equal access to the best health care possible without regard to ability to pay.

- (2) The SDPA believes that all Ontarians should be allowed to utilize the pharmacy of their choice.

- (3) The SDPA believes that all Ontarians deserve a high standard of care from the pharmacist who serves them and that this standard of care be set and maintained by the Ontario College of Pharmacists.

- (4) The SDPA believes that a system of remuneration for the services provided by pharmacy be fair and reflect the level of service that is provided.

With regard to Bill 26, we have to offer the following subjects for discussion:

With regard to plan design, we know that since the drug cost component of the ODB prescription represents over 80% of the total price, this component must not be neglected in attempts to control costs. Large-quantity prescribing has led to high levels of wastage of drugs.

Wastage is a very significant problem and one that is not being addressed.

The SDPA has just completed a month-long medicine cabinet cleanup program, and although the final results haven't been tabulated yet, we can offer the following data: Of the 21 pharmacies that have reported to date, \$17,000 of drugs have been collected for which the ODB program has paid. These are drugs that are not going to be taken and are going to be discarded. If this number is extrapolated to the 2,500 pharmacies in Ontario, the figure would rise to over \$2 million. This was collected in a one-month period. The reasons for not finishing prescriptions can range from suffering an undesirable side effect, lack of effectiveness, resolution of the problem or just poor patient compliance.

There is a trial prescription program in place in British Columbia, and data certainly suggest that very significant savings can be achieved from such a program. Early data state that of all the prescriptions in the program, 57% of the prescriptions were not renewed after the first trial portion was dispensed. The program has been so successful in British Columbia that the Ministry of Health, in conjunction with the BC Pharmacists' Association, has expanded the number of drugs in the program to achieve even more savings. This is just another example of a cooperative effort achieving desired results. This did not cost the taxpayer a dime, nor did it reduce coverage.

The SDPA fully supports the removal of the PC-34 no-substitution form as outlined in Bill 26. This form, when completed by a physician, would allow a prescription to be filled and reimbursed for the name brand product even though a lower-cost equivalent product is available.

Prescribing guidelines must be put into place whereby existing therapies are encouraged over the newer, more expensive alternatives. This is entirely possible in the electronic on-line environment that the Ministry of Health and pharmacies now operate in. This type of system is already in place in the private sector and hospital settings, and there is no reason for the ODB program not to adopt it. If the ODB program were paying \$16.92 for the drug cost rather than \$43.24, we may not even be here today. Why shouldn't the Ministry of Health utilize pharmacists to administer a drug utilization review program?

I'd like to refer to a study that was done in 89 hospitals in Canada. They found that for every dollar they invested in a pharmacist's time devoted to DUR—drug utilization review—they had a \$30 return in reduced medication costs. I don't want you for one moment to get complacent about the fact that you hear that drug cost increases are being kept to under CPI, especially when you see the introductory cost of new drugs coming out into the market. This is a very misleading statistic that cannot be considered a sign of any kind of control over drug costs.

With respect to copayments, we acknowledge that many provinces in Canada have a copay system. In theory, copays are meant to curb utilization and to share costs with the users, along with making them more aware of the value they are receiving. The evidence for copays is much too unclear to make recommendations promoting it, for the following reasons:

(1) It is impossible to tell whether savings derived from copays are from decreased utilization of discretionary medication or necessary medication.

(2) What are the costs of hospitalizations or long-term morbidity from lack of compliance with respect to medications like anti-hypertensives?

(3) In Quebec the implementation of copays led to a decreased utilization during the first year, but levels returned after year one to previous levels.

The SDPA does fear that the people who will be hurt the most are the low-income ODB recipients who will not have their prescription filled so that they can purchase groceries.

With respect to the actual recommendations in Bill 26 on copays, which are a \$2 flat fee copay or a copay based on the dispensing fee for higher-income ODB recipients, the SDPA has the following comments.

The SDPA can't support the copay proposal because it will not achieve the goals that they are trying to achieve. This copay proposal will cause undue hardship to those Ontarians who can least afford to pay. It does not make the Rx recipient more aware of the value of the prescription. All of the other factors that we have itemized are not fully understood yet by anyone and, finally, there are many other measures for cost savings possible. These measures should be exhausted before any copay system be implemented. At that time, if it becomes necessary to implement a copay system, the SDPA would be able to offer its suggestions on how it might be implemented to better achieve the desired result.

With respect to price deregulation, the current system of best available price, BAP, may not be the perfect system of drug price controls, but we feel that it is a fair system and better than the one that is proposed in Bill 26. The BAP concept allows for a price to be set in the Ontario Drug Benefit Formulary for the drug price at the best price found in Canada.

May I add that this also takes into effect competitive forces, so that when pharmacists or purchasers seek out better prices, those better prices get reflected in the ODB Formulary. There is a changing, evolutionary process in it and competitive forces are in place, so it is a good system. It ensures access to those prices for all pharmacies and, in effect, to the clients of those pharmacies whether they be a cash customer or a third-party payor for a local employer.

The concept of deregulation would take away this access and put pharmacies in northern Ontario at a distinct disadvantage with respect to the purchase cost of drugs. One only has to examine the large variation in drug price for products in Canada, for instance, from province to province. When one looks at the difference between pharmacy purchase and hospital purchase prices. This would have to be reflected in the final prescription price. The people of northern Ontario know well enough the extra costs of living in the north.

The aspect of the drug price being regulated for the Ontario drug benefit prescriptions but not for other prescriptions is a bit puzzling also. How does the government propose we establish a particular regulated price for one tablet in a bottle and another deregulated price for another table in the same bottle?

Finally, with respect to the Ontario Pharmacists' Association as pharmacies' united voice, the SDPA believes that a cooperative effort among all the stakeholders in the ODB program will result in the long-term savings and cost controls that the government is seeking. Many of Ontario's large private and public companies have found that this cooperation and multilevel involvement has been very successful in their efforts to control employee benefit costs. Bill 26 would end this relationship between OPA and the Ministry of Health. This consultative relationship can only lead to further savings through these cooperative efforts and the expertise that the members of OPA can lend to this program. Excellent program models are already in place in other provinces such as Quebec, where the provincial association works as a close partner with the Ministry of Health.

It is for these reasons that the SDPA is suggesting that the Ministry of Health continue to deal with OPA as a representative of pharmacy in Ontario. The result can only lead to programs to help achieve further cost savings and enhanced programs to ensure the highest standards of care are maintained in the province of Ontario. We at this time also would suggest that the Ministry of Health continue its relationship with the Ontario Medical Association in the same light.

In conclusion, the SDPA would like to thank you for this opportunity to express our ideas. We feel that the recommendations made here are based on a sound understanding of the provision of pharmaceutical care to the people of Ontario. Pharmacists, as the experts in drug therapy and as the end provider in the ODB program, not only have a good understanding of the ODB program but must always keep the best interests of the patient in mind. The recommendations made in this presentation preserve this very important mandate while at the same time will ensure a cost-effective and efficient system for the taxpayers in Ontario.

I'd like to point out that I've included at the back of my presentation to you studies and abstracts for all the data I've included in my presentation.

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The Chair: Thank you. We have about three minutes per party for questions, beginning with the government.

Mr Clement: You've certainly given us a lot of information and a lot to think about as a committee, and I thank you for the time that you put into your presentation. You've raised a number of issues.

With respect to the replacement of the best available price, we've been hearing what I guess one could call conflicting testimony or different predictions, because really all we're doing is predicting the future, as to what will occur to drug prices as a result of moving away from that system.

Certainly the pharmaceutical manufacturers are of the view that prices could well go down, and certainly the structure of the industry, as I understand it—if you look at it from a worldwide perspective, most of the pressures within the industry are to cap costs, to reduce costs. What's happening in other jurisdictions throughout the world is that people are organizing in groups like HMOs or what have you to put a cap on these costs and to have better bargaining power with the manufacturers. Could

you see something like that working in the north in some form?

Mr Grillanda: I think that the forces are already in place. When pharmacists and groups—HMOs, if you want to use an HMO—seek out a better price and a company agrees to provide a product at a better price under the best available price system, that then becomes the best available price. So there are forces in place to promote competition.

One question I'd like to ask you is, if deregulation is going to end up with lower costs, then why is the Ministry of Health not deregulating the entire drug benefit prescription portion of the drug cost? They want to maintain regulation there, so they're fearing that drug costs may go up as a result of this.

Mr Clement: No, I think we like our bargaining power right now, actually. The government is a big buyer, so we've got some bargaining power that you as a pharmacist don't have, and I acknowledge that.

Ms Lankin: Exactly.

Mr Clement: Let me finish my answer, Mrs Lankin. But that's exactly why the other aspects of the industry are important. The pressure is down, the pressure is buyers coming together to bargain in that way. Ontario doesn't need that added incentive or position, because it's a big buyer of drugs, quite frankly. In fact, by being an active buyer in the market, we will affect prices in terms of a downward trend. But we're all predicting, I guess. To be fair to everyone, we're all predicting.

I'm glad that you mentioned the no-substitutions changes and your group's support of those changes, because we've also had some deputations fearing that somehow this was going to affect citizenry in a negative way. Certainly there are calibrations that can be done through regulations, perhaps, to meet some of the valid concerns that were expressed. But from your point of view, no subs is the way to go?

Mr Grillanda: We don't see a problem with it. There are so many options available that this should not create any undue hardship. Many of the name-brand pharmaceutical companies produce generic equivalents of their products in the same pill presses at 30% less than they're selling their name-brand product for.

Mrs McLeod: Just to follow Mr Clement, I think he's absolutely right when he says the government has a lot more bargaining power to get a good price for medications than a sick individual who's supposed to go from pharmacy to pharmacy to see if they can find a good price for the product before they purchase the drug. That's the implication of this bill.

It is obviously in northern communities, which your brief points out, a particular concern where there is not the same degree of competition or the volume of purchases or sales. It is really frightening that a government brings in such a major change and everybody is just predicting what the drug price may do. Having said that, that's not my question for you.

I want to come back to the copayment issue. I appreciate your brief because you've provided not only a focus on the specific concerns but a great deal of background information. In addressing the copayment issue, I appreci-

ate that you've addressed the fact that the payment itself is a concern for those who are on those low incomes.

But if I'm understanding the information you've given us correctly, and I think this is an important point for the government to understand and to think about in looking at the copayment, you're saying that all the studies that have been done show that a lot of the increase in drugs can be attributed—in this particular study 15.1%—to increased quantity being prescribed per claim.

Logic says that if individuals who don't have a lot of money are being asked to pay a copayment or their dispensing fee, physicians are going to prescribe larger quantities in order to save them additional costs of dispensing. So the implication of a copayment is to have larger volumes of the drug prescribed. If that's the case and that in turn increases utilization of the drugs, the government's costs even under the ODB plan are going to go up because more drugs are going to be used under a co-payment system. Am I following the logic through?

Mr Grillanda: No. Increased prescribing doesn't increase utilization. A person who is taking three tablets a day isn't going to start taking four tablets a day because they have a larger prescription. However, there is a greater opportunity for loss of money because of wastage. We just pointed out in our medicine-cabinet cleanup program, people have therapies changed. They can't take drugs any more, things change, and so when they have a large supply of medication in many cases lots of this gets thrown out.

Being smart consumers, they're going to want to get the most prescribed at any time, thinking that they're going to save money by reducing the number of dispensing fees they pay. Well, when you take into consideration that 80% of the total prescription cost is in the drug cost component, there is a big opportunity for wastage and significant cost overruns because of this wastage.

Large-quantity prescribing is one of the things that is going to be promoted by a copay system, and it certainly seems there's enough evidence to show that this is not a way to save money. Large-quantity prescribing is appropriate when somebody's been stabilized on a medication and there is no foreseeable change in the future. In that case it's appropriate. When a patient comes in for an initial prescription on a medication and ends up with a three-month supply of it and throws 99% of it down the toilet, that is criminal.

Ms Martel: I want to return to the issue of drug deregulation because it's interesting that this initiative was not announced in the economic statement, nor was it found anywhere in the Common Sense Revolution, and it's telling that this is the only jurisdiction in Canada that is moving away from regulation of drug prices. People should ask themselves, why are we doing that?

I want to follow up from Mr Clement's comments that the government can get a really good price. Ms Shaw here represents a community pharmacy. How do you think your community pharmacy is going to do, Ms Shaw, when you have to go to the big drug manufacturers to buy drugs and when Shoppers chain goes to the big manufacturers to haggle for the price of drugs? Who do you think's going to get the best available price?

Ms Claire Shaw: Well, it's rather obvious who's

going to get the best available price: the person who is dispensing more medication is obviously going to get the best available price, and when Shoppers has 1,000 stores across Canada, they obviously have an advantage over myself or, for that matter, over any buying group that the local pharmacies in Sudbury could put together.

If you do a cross-section of northern Ontario, we're in a big centre in terms of northern Ontario. But if you take the small number of communities that are across northern Ontario—there are about 185; outside of five of those the rest are quite small—how do you think people in northern Ontario are going to end up in terms of paying for drug costs? In most of those communities what you're going to have are small community pharmacies that aren't going to have the buying power, the buying authority, that the big chains do or that the government does.

Mr Grillanda: More importantly, I'd like to point out that not only will pharmacies be disadvantaged but also the people who frequent those pharmacies, because they don't have the option of going to any other location. They're restricted because they're immobile, they're seniors, they're homebound. They are restricted to where they can purchase medications, and if the pharmacy's paying more for the medications, then ultimately the consumer is going to have to pay more for those medications. So this is very unfavourable to northern Ontario for the most part.

The Chair: Thank you very much. We appreciate your involvement in our process and your presentation.

ACCESS AIDS COMMITTEE OF SUDBURY

The Chair: Our next presenters are from the ACCESS AIDS Committee of Sudbury: Ann Matte and Paul Ham. Welcome. You have a half-hour to use as you see fit. Any time for questioning that you leave would begin with the Liberals.

Ms Ann Matte: Good morning, ladies and gentlemen. My name is Ann Matte. I am the executive director of the ACCESS AIDS Committee of Sudbury. ACCESS is a community-based, non-profit AIDS organization. We provide service within the districts of Manitoulin and Sudbury. As well, individuals living within the 705 area code have access to us through a toll-free telephone line. Therefore, we do work with people who are living with HIV throughout northeastern Ontario.

In northeastern Ontario there are known to be at least 300 people living with HIV, and since 1989 there are at least 100 people within this part of the province documented to have died from AIDS-related illnesses.

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As you travel this week through this part of the province, I suggest that you pretend that you have to travel the distances yourselves between our communities for health care services. From Timmins to Sudbury you have about a three-and-a-half-hour drive one way. If one lives in Hearst and has to see a specialist at our HIV clinic, that person will travel six hours one way.

Sudbury is the health care centre for northeastern Ontario. It is the centre of excellence for cancer treatment, cardiac care, trauma, paediatrics. Sudbury is also the centre for HIV-related health care services in this part

of the province. I'll take this opportunity to thank you for being able to address your committee about the omnibus Savings and Restructuring Act, 1995, Bill 26.

The title of this act clearly identifies its objective. Economics is clearly the issue at hand. It amends over 40 pieces of legislation, repeals two acts and adds three new acts. This bill addresses a plethora of major areas, ranging from government borrowing to corporate income tax to which physicians will be able to practise where in this province.

There is a phrase that is repeated frequently within the proposed legislation concerning the Minister of Health who "considers it in the public interest to do so." It would appear based on this piece of legislation that the sole criteria that is in the public interest is economics.

We agree that we taxpayers in this province also need to get our fiscal house in order. This bill creates more problems which in the long term will cost even more. This bill lumps the health care of the citizens of Ontario in with changes to the Mining Act. One might assume that Ontarians are, according to Bill 26, a natural resource. We are sure that this government assigns value to the health, and we know that they do, of Ontarians.

We are concerned that this legislation has been drafted in haste. We expect carefully maintained quality health services even with financial restructuring. This bill portends a great amount of power to a small number of people with no checks and balances. This bill is creating insecurity among people living with HIV as it renders people helpless and hopeless in the determination of their health care needs. Put in very simple terms, this bill is scary. Our intent is to highlight some key issues as they might impact on people living with HIV in northeastern Ontario.

About the Health Insurance Act, schedule H, insured services: Which insured services will be covered by OHIP? Who will define what criteria are medically or therapeutically necessary? We understand that the criteria that the Minister of Health can use to determine who is entitled to a particular service will include age, who provides the service and the type of facility in which a service is offered. Will this mean that some people will be covered by OHIP and others not? If a person living with HIV lives in Iroquois Falls and does not go to a physician with the appropriate designation nor near the appropriate facility, will that person have to pay out of pocket for that particular service? Health care service accessibility is not equitable across this province as it is now.

About physicians' eligibility: Many people living with HIV are seen by physicians who may not be affiliated with a hospital or a specific facility, especially in northeastern Ontario. If the specialists or primary care physicians no longer qualify, what recourse will their patients have? This legislation, as proposed, allows for no manner of public challenge to decisions on physician eligibility.

The physicians in this part of the province who care for people living with HIV are precious and few. They are dedicated and want to be in the north. What recourse will patients have should their physicians no longer be classified as eligible?

Hospital user fees: People living with HIV over the course of their lifetime require frequent hospitalization to deal with complex health problems. The regulations proposed under this section may prevent these individuals from receiving health services that they will require to survive life-threatening infections. By the time an individual requires hospitalization, usually one is no longer able to work for a living. Hence, one is surviving on a fixed income. The possibility of copayments for insured hospital services will definitely be a barrier to care.

The preceding have merely been a highlight of some problem areas that we have identified in a short period of time with Bill 26 as it relates to health. We're also concerned with wording in schedule M as it relates to municipalities. Will a municipality have the power to dissolve a local board of health? If so, what happens to anonymous testing, needle exchange programs and AIDS education done by public health?

This bill is all-encompassing. How can this committee possibly bring together all of the expertise required to make the best and most informed decisions surrounding all of these recommended changes? We strongly urge you to recommend splitting this bill into its appropriate sections so that more time can be given to key issues. As well, should your committee recommend any changes, the opportunity for feedback from experts in those areas should be incorporated into these recommendations.

We acknowledge the government's desire to move quickly on fiscal matters. However, this bill addresses directly the health of citizens of this province. The undue burden that will be borne by people who are ill as a result of certain pieces of this legislation cannot be seen as acceptable by responsible, intelligent decision-makers in this province.

Mr Paul Ham: Good morning, ladies and gentlemen. My name is Paul Ham. I have been living with HIV for the past four years.

As a person living with HIV in northern Ontario, I consider myself quite fortunate to be residing in Sudbury, which is the centre for the north for medical technology. In speaking with other individuals who are living with HIV and reside outside of the Sudbury area, they have to travel great distances to obtain specialized medical care for HIV and AIDS.

Those infected struggle with enormous social pressures and stigmatization from this virus. People living with HIV also live in fear: fear of disclosure. Many often die without ever having disclosed their HIV infection to friends and even family.

I will highlight today those recommended changes to the health legislation that are causing great concern to myself.

Proposed legislation changes to the health insurance, schedule H, concerning disclosure of confidential medical information will only amplify the fears of people living with HIV and AIDS. Early intervention has shown to improve the quality and length of life for people living with HIV, making HIV a chronic, manageable disease. For fear of disclosure, some may choose not to get the proper treatment needed. The outcome of this fear will be that the disease will progress at a faster rate. The probability of becoming very ill and having to be hospitalized

for an extended period of time will thus occur at the cost of the taxpayers.

We who are living with HIV rely on confidentiality with our care team, and build trusting relationships with them so that our health is of number one concern. Why would a Minister of Health and members of cabinet need to see my personal medical files?

The proposed changes to the Health Insurance Act, the Ontario Drug Benefit Act, the Independent Health Facilities Act and the Public Hospitals Act would be a violation of my fundamental human rights that as a Canadian I am proud of having.

In regard to anonymous testing, people who suspect infection with HIV will be even more hesitant to be tested if there is a slight possibility of disclosure as one enters the next stage of the health care system. As proposed, the minister will be able to obtain this information and, if he so chooses, can share this information with insurance companies without the consent of the individual.

The ramifications of this proposal could be devastating, as fewer people will want to get tested. Those infected will unexpectedly be hospitalized with full-blown AIDS, which again will be a burden on the taxpayer if the individual has no other means of payment.

The proposal to impose a user fee for prescriptions can be very costly to those living with HIV and AIDS. The quantity of medication needed at times to prevent infections can be very substantial. Although the user fee of \$2 per prescription appears to be quite low, a person living on a fixed income requiring a large quantity of medication would definitely feel the cost burden.

With regard to the proposed drug list under the Ontario Drug Benefit Act, it is my understanding that this list will specify not only the name of covered drugs, but also the specific concentration and form of the drug. This does not allow for any flexibility for a person living with HIV or AIDS.

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HIV can attack any part of the body, and if the only means of drug treatment is via intravenous and it is not covered, is it fair for the individual to have to pay for it because they cannot take the proposed concentration and form of the drug? Will this mean that I will have to be hospitalized at a much greater cost in order to get my medication?

Furthermore, those living with HIV and AIDS in isolated communities may have a higher financial burden when obtaining AIDS-related drugs and/or treatment because of what is being proposed under this legislation.

As a person living with HIV, part of my life routine is the ongoing monthly visits to the HIV-AIDS clinic. I am deeply concerned about the financial and social implications this bill will have on myself and others living with HIV and AIDS in northern Ontario.

The reality is that we who live in isolated areas have enormous fears of disclosure and the possible consequences of being outed. I strongly urge you to revisit the recommended changes to the health schedule. I believe that more time is needed in drafting the health legislation, as well as consultations with the experts from the community in these specific areas.

Thank you for listening to me. I am an expert on HIV.

The Chair: We've got about six minutes per party left for questions, beginning with the Liberals.

Mr Rick Bartolucci (Sudbury): Thank you very much for your excellent presentation. Let me quote from Tom Wright, who is the privacy commissioner. He states that "these schedules have the potential to significantly increase the amount of personal, health-related information that will be gathered, significantly increase the number of uses that may be made of this information and raise the possibility of new and troubling disclosures of the information." Would you agree with him?

Mr Ham: Yes.

Mr Bartolucci: What impact will that have on the AIDS community and those with HIV?

Ms Matte: Within this community for the last eight years, we have been encouraging people to be tested early, because HIV is a chronic manageable disease today. It has been a struggle because people are so afraid of disclosure, especially living in small communities. We now have anonymous testing. Anonymous testing in Sudbury is used by people who come here from Timmins, who come from North Bay, from areas where it is not offered. However, what happens then is once someone is tested, as they then enter into the next phase, which is then going to see a physician, going into hospital, there will not be a guarantee of confidentiality of that status. Hence, that will then prevent people from seeking further assistance with their health.

Mr Bartolucci: The commissioner has recommended 30 amendments to that section of the legislation. I know that you're in favour of most of those recommendations for amendments. Let me talk a little bit about copayments because the SDPA and the OPA obviously have suggested that copayments don't work. They will have a definite negative impact on your community, and I'd like you to outline the very, very grave concerns you have with regard to copayments.

Mr Ham: Most of the people I know that are living with HIV and AIDS in the Sudbury area are living on fixed incomes. I think by imposing copayments, you're really going to impose on their quality of life also. With HIV and AIDS you really have to manage your health and eat very nutritiously. If you're cutting into their nutritional intake because of paying for medications that they also need, It's going to be a much harder task for them to live on a lot longer in a good quality of life.

Mr Bartolucci: Would you say that it's safe to say that it may be a short-term fix with dire long-term consequences?

Mr Ham: Oh, absolutely.

Mrs McLeod: I just want to follow up on a couple of other questions that arise from your brief, and again appreciate what you've indicated about the impact of copayments. You may not be aware of something else that we've discovered in the bill, that the government can decide to impose different copayments for different classes of individuals. We have no idea what that means and what the implications of that may mean, but that's something else to watch for.

I would think by your comments about flexibility that you would want to see there be at least some process for

physicians to ask for a substitute drug without it having to be covered fully because of the kinds of reactions that AIDS individuals particularly can get to specific drugs. Would I be right in assuming you'd like to see some substitution process in place?

Mr Ham: Absolutely. AIDS can often affect your oral cavities and if you can't swallow pills, then you need to take the drug treatments in different means.

Mrs McLeod: Right. You make a very brief comment about people with HIV/AIDS in isolated communities experiencing greater costs. I assume you mean the discussion we had earlier about how deregulation can lead to higher costs of drugs, particularly in smaller communities.

Lastly, a question, and this is a difficult one to read, but in the beginning of your presentation you talked about the government stepping in to determine what is going to be medically insured, covered by the health care system as medically necessary and in some cases therapeutically necessary. I guess one of the concerns I have is, where does something like palliative care fit with a government that is driven by a financial bottom line and has the power to decide whether something is medically necessary? I suspect you would say that palliative care may not be necessary in terms of the prolonging of life but is certainly necessary in terms of the continued relief of pain and the comfort of the individual.

Ms Matte: I think it will be very important to have and to see what the definitions will be of medically and therapeutically necessary services.

Ms Martel: Thank you to the presenters, particularly to you, Paul, for relating your own personal story, which always makes these things come a bit closer to home.

Let me ask you about the copayments. I don't have a good sense of not so much the types of medications, but the amount of medication that you or someone else might have to take. Similarly, what kinds of monthly costs, for example, would we be looking at for you just to purchase medication?

Mr Ham: I think, depending on the type of medication, when you become diagnosed with full-blown AIDS, your cost for medication is really substantial, depending on the infections that you're getting, the infections that you're trying to prevent yourself from getting, because we deal a lot with preventive medication right now. Our doctor at the clinic, if your T-4 counts are at a certain level, will hand over some medication to you, so it could be preventive of PCP, let's say. I'm aware of some individuals who take handfuls of pills three times a day just to keep going. So it can be a very large quantity.

Ms Martel: So when you place that in the context that you're probably already on a fixed income because you may not be working, and you're also trying to pay rent and then go back to a diet that has to be followed, you're talking about most people ending up in pretty desperate straits by the time they're finished even with just the \$2.

Mr Ham: Oh, most definitely.

Ms Matte: Some of the costs that we're seeing on a monthly basis can range anywhere from \$400 to \$800 a month for medication.

Ms Martel: One other thing, and this goes back to the

deregulation. Earlier, when this committee sat in Toronto, there was a suggestion by one of the government members that people could kind of go from pharmacy to pharmacy and try to get the best available price that way for drugs.

Let me ask you, for the people you serve, or for the people you know, Paul, or for yourself, particularly those who live in small northern rural communities: What is the likelihood of them being able to shop from pharmacy to pharmacy for the best available price and what is that going to do to their health care?

Mr Ham: For most people who are living with HIV and AIDS and have progressed further with the illness, it takes a great effort to even go to the HIV/AIDS clinic once a month to get tested. So to go out shopping around for prescriptions is really inconceivable for them. Basically, they're stuck with the pharmacist they started with.

Ms Matte: And depending on what small community one lives in, how many pharmacies will they have to choose from?

Ms Lankin: Even if you are lucky enough to have multiple pharmacies, I think one of the very important things with respect to health care management is for you to have a relationship with your pharmacist, who knows about all the different medications you're on and who is helping you manage your drug treatment program. If you could get one drug at a best price at one pharmacy and another drug at a best price at another pharmacy, what happens to your coordination of care at that point?

Mr Ham: I think that after you do establish a good relationship with a pharmacist, you try not to sway from them very often because they are basically looking after your own health, and if there is some kind of contradiction with the drugs, they definitely let you know about it.

1020

Ms Lankin: So I would think that in this case, persons with HIV and AIDS would want to stick with their one pharmacist, which means that the government's theory that people shopping around will be the competitive force that will drive prices down goes out the window a little bit.

I wanted to also ask you about the concern you raised around specialists and their hospital privileges and whether or not they can continue to practise their specialty in an area, particularly given the problem that we have had in Ontario in general, but most particularly in northern Ontario, in encouraging doctors to develop a practice where they understand and can work with and can be expert in dealing with people living with HIV/AIDS. Could you just elaborate a little bit more on what you see as some of the problems in the act and what it might mean for yourself and the people you know in your community?

Ms Matte: In this brief time that we've had, our concern is in the criteria for physicians to be identified as eligible; there are specific criteria. But nothing is guaranteed. So what happens to that one physician who may not meet all of the criteria, who loses his or her eligibility, and that is the one doctor serving that person in Opatatika and there's not a hospital that's maybe an HIV-related hospital—the age is wrong? So does that person then have to pay that doctor for services because

the insured services are no longer covered?

Those are some of the concerns, because the physicians in the north are limited in terms of seeing people with disabilities, people with HIV. They may not now be identified as specialists.

Mrs Helen Johns (Huron): Thank you for your presentation today. We've heard from a number of AIDS organizations and we appreciate your time. As you may or may not know, the minister has had AIDS as a high-priority item. We believe that it's important to keep funding it and we believe that some of the changes we're making, hopefully, will do that.

I just want to clear up a couple of what I consider to be misnomers and to clarify some issues that have come along through the hearings that we intend to rectify; first of all, confidentiality of information. It was never our intention that your records or my personal records would be plastered throughout Ontario. What we were hoping to do with that was to be able to use that to trace down misuse and inappropriate billings or uses in the health care system. Because it has raised such an issue, we will be making amendments to that. We're listening to what people say, and if you have specific things that you think would help us in making those amendments, we'd love to hear from you in that regard.

Also, what was suggested here today, that different copayments are going to come about as related to age or different diseases or anything we arbitrarily pick, it's just not the case; it's not in the act anywhere and it's not something we've said, so I want to clear that up to make sure it's not the case that people believe that.

The notion of "medically necessary" also. It is broadly determined by the medical profession at large and by experts in the scientific community. These experts, which include the central tariff commission of the OMA and a number of different groups, will continue to determine what's medically necessary, will continue to determine the services. So it's not basically the minister coming along and saying, "No, not medically necessary."

Ms Lankin: Mr Chair, this is outrageous.

Mrs Johns: And what you've said isn't? Give me a break. Implying that we're going to be laying off palliative care? Give me a break.

The Chair: Excuse me. These three people sit nice and quietly while you make your presentations. I think they deserve the same respect.

Mrs Johns: I was saying, I think, that drugs are an important aspect of treating AIDS. In the past, there's been a lot of pressure on which drugs are listed in the formulary and which aren't, and we've in effect taken drugs off to be able to put new ones on. In many cases I view that as being a problem, and the fact that we can't get new drugs on as quickly as we need to for people with AIDS as they're coming out with new ones.

We believe that by putting a copayment on we will be enabling new drugs to be available to people at a faster rate, especially people with AIDS. Can you comment on that for me, the need for drugs in a hurry, new medications that are coming out, that kind of thing?

Ms Matte: With our history to date, that's never happened, that it doesn't happen fast enough, and I don't

see how copayment is going to facilitate it—even something like Gravol, and that's not only for people living with HIV; people with cancer who need access to that, and different forms of it. So based on what I'm reading in this legislation, things have to be changed in it in order to even follow through with what you're saying to me right now. I don't see that happening with what is written in the recommended changes right now.

Mrs Johns: Can I just clarify that? Are you saying to me that the drugs are coming on to the formulary as quickly as they are needed?

Ms Matte: No, they aren't. They aren't at all. I don't see, though, how copayment is going to change that, because even the medications that are needed to be there aren't there now. They've been removed.

Mrs Johns: I want to talk about the physicians for a minute. I heard you say, sir, that there were 300 people with HIV and a specialist, I think you said. Are there enough physicians in Sudbury and the area, enough people who deal with HIV as their primary focus? And what do you think we can do as a government to help that situation if it is a problem?

Mr Ham: No. Actually, people with HIV are really underserved by physicians up here in northern Ontario. We have to seek out specialists to get our infections looked after. Even general practitioners—you really have to shop around to find someone who will be comfortable enough to deal with HIV and AIDS. So we're really underserved up here in that regard.

Mrs Johns: Any suggestions or things that you think we could do that would assist you in that regard?

Mr Ham: We have ACCESS, and the HAVEN program has sent out many requests for doctors to attend meetings and to introduce them to the mentor program through Sunnybrook hospital, but we haven't had a really positive response towards that.

Ms Matte: When physicians take on the charge of people living with HIV, they become extremely busy. They then become the primary care and the specialist in many different facets of the body of a human being, which is very different from a lot of other chronic illnesses. Physicians need support. They need perhaps some extra financial reward, but most of all they need support from the government, from their own medical association, to pursue and continue to offer services to people living with HIV. They don't, I believe, need any more hassles.

The Chair: Thank you for your presentation. We appreciate your interest in our process. Have a good day.

Mr Bartolucci: Mr Chair, a point of information: Mrs Johns made a point with regard to disclosure of information. Is it my understanding then that the government has altered its position, and from here on in, in this bill as we discuss it, the release of information will not take place unless the individual to whom the information relates agrees to it? Is that correct? Is that my understanding?

Mrs Johns: We're saying that we're looking at making amendments to that portion of the act because we've heard so much from the people here.

Mr Bartolucci: Mr Chair, could she directly answer my question?

The Chair: I believe she did answer it.

Mr Bartolucci: No, she didn't.

The Chair: They're looking at making amendments to the act.

Mr Bartolucci: I didn't ask if they were looking to make amendments. I asked, will this be one of the amendments that they're going to incorporate in this act, that disclosure of information will not take place unless the individuals whom that information deals with give their consent? Is that an amendment?

The Chair: Our objective, in coming to Sudbury and going to Timmins and going to Thunder Bay, is to listen to public input; it is not to argue among ourselves about what we are or are not going to do. I suggest we continue along in the vein that we have so far, and that is to allow the people of the community to make their presentations. When we get into clause-by-clause back in Toronto, that is the time for us to talk about those issues.

Mr Bartolucci: But, Mr Chair, we cannot mislead the people here, whether we do it intentionally or unintentionally. If in fact that's not the case, then I'd like to know, because it will obviously determine the way we question over the course of the next week and a half.

Ms Lankin: Mr Chair, if I could add to this, you will recall that in Toronto on the first day of hearings the minister indicated another area of this act that he intended to amend. I asked him very specifically, in my opportunity to put questions to the minister, if he would ensure that for any areas they are considering amendments, those amendments be tabled prior to us going out for these two weeks of travelling hearings so we would have an opportunity to look at those and the public would know, so the very limited time we have to talk with people wouldn't be spent on areas the government already knew it was going to amend.

1030

The minister said, "Absolutely." In fact, he referred to the fact that he had always found it frustrating himself, as a member of opposition, if that didn't happen and the amendments didn't come in until the very last minute under the rules, which is the first day of clause-by-clause.

We have yet to see any amendments tabled, and I want to put this request one more time to the government, that it table the amendments so the public knows and the opposition members know what's left on the table for us to debate.

Mrs McLeod: Mr Chair, I'd like to table a direct question to ministry staff. I believe that's in order.

The Chair: Yes, that is in order.

Mrs McLeod: I've given up hope that we're going to see the amendments before we continue the debate. Because there has been a very clear indication that the government is looking at amendments in the area of disclosure of information, and based on the fact that this presenter had indicated a concern about disclosure of information under schedule G as well as under schedule H, I would like some clarification from ministry staff about whether amendments relating to disclosure of information will apply both to schedule G, the drug benefits act, and schedule H.

Mr Clement: A point of order, Mr Chair.

Mrs Ecker: Mr Chair, they've had a lot of time. We would like to respond, if we may.

The Chair: I would like to play a little hardball on

this issue. We are not here to argue among ourselves; we are here to listen to presentations from the public. I am going to insist that we get on with that process.

Thank you very much for your presentation.

Ms Martel: May I raise a point, Mr Chair? You can tell from the room overflowing with people right now that there is a great deal of interest in these public hearings. I wonder if you might request that the hotel put in more chairs for the people standing at the back.

The Chair: I will do that.

SUDBURY AND DISTRICT LABOUR COUNCIL

The Chair: Our next presentation is from the Sudbury and District Labour Council, represented by John Filo. Welcome to our committee. You have half an hour of our time. The floor is yours. Questions will begin with the New Democrats.

Mr John Filo: I'd like to begin by welcoming the committee to Sudbury. As you can see, the response in our community is overwhelming. We're all interested in what you're doing, and I think the turnout here is indicative of that interest.

I want to emphasize how much we feel this committee can contribute to Ontario society if it takes its mandate seriously and does listen to the public. It can be said that many of the things we do end up as little footnotes to history. If this committee behaves in an appropriate fashion, this committee may in fact make history. A lot of us in this community of Sudbury have a great deal of hope and would like to express a great deal of support for the efforts of this committee. I know you tend to be chippy with one another, and that's maybe part of the process, but we're all citizens and we expect value for our money and we expect reality; we don't expect posturing and we don't expect things that aren't really what they are.

I represent the Sudbury and District Labour Council. I'm a first-generation Canadian. I'm a union man, my father was a union man, and the union movement is proud of its contribution to this province. I know that some of my colleagues who are Conservatives denigrate the contribution of union—they think we're too powerful—but if you look back and read some history, you'll see that it was unions that introduced the concept of medicare, introduced concepts of free public education, for example, and a lot of the things that we in this particular society now take for granted.

I've worked in the union movement for 30 years. I haven't seen too many of my colleagues live beyond their means. I've seen retirees and I've seen seniors who have had marginal employment, who worked as labourers, as my father did, and who had the good fortune, the work ethic and the skills to build homes for their families and to educate their children.

By profession, I'm a mineral exploration geophysicist. I've been to every continent, with the exception of Australia and Antarctica, and I can tell you right now that the countries worth living in in the world you can count on the fingers of both hands. Ontario is a blessed province. We want to keep it that way.

I know that this committee and the Tories are well-

intentioned, but well-intentioned people make mistakes. The substance of what we're here to discuss will focus the attention of our community on what we feel are mistakes that are being made, and perhaps we can have a change in the process.

For example, this bill was introduced while the opposition members were still in the lockup, and as a presenter, I was given notice only a few days ago that I have standing before this committee. I had hoped to have had 25 copies of my brief ready for you. I do not have it, but I shall mail it to you at the earliest opportunity. My staff, all of one person, is busy working on it right now.

This is a complex bill. About 47 or 48 bills are actually involved, depending on who you use as a reference. One has to be a speedreader to read this bill and the supporting bills it refers to, plus the thousands of pages of commentary these contain. Not only do you have to be a speedreader, but you have to have the IQ of an Einstein.

I have to begin by saying that in my opinion and in the opinion of many people who are committed to the democratic process, omnibus bills were never meant to be such complex documents. They were meant to be house-keeping documents, things where you cross the t's and dot the i's, but not things that make a significant difference to the way our society operates. This does in fact fundamentally change some of the ways in which business is supposed to be conducted in this beloved province of ours.

Democracy is not well served if you don't have a well-informed and involved citizenry. I want to read to you the definition of a political system, and perhaps the members of the committee can then determine the degree of applicability to the present government.

"A system of government characterized by rigid, one-party dictatorship, forceable suppression of the opposition, unions, other—especially leftist—parties, minority groups etc, the retention of private ownership of the means of production under centralized government control."

That's a definition I picked out in part from the Webster's New World Dictionary. Friends, it's the definition of "fascism." I know this is an extreme analogy, but democracy—and I've lived in these other countries. I've lived in countries where the police have the right to execute you. I come back to Ontario, and really, I feel like the Pope. When the Pope visits a country, he gets down, he kisses the ground. Ontario is a very privileged and a very generous and a very caring province. I think we have to do our bit to protect the nature of our province.

1040

I can give you a few names. Of course, they're just names to many people, but they'll have significance to you: Colin Perry, Eugene Upper, Dianne Cunningham.

You speak about debt, and you say: "We have to get our debt in order. We've lived too high off the hog." Sure, debt is a problem, no question about it, but if you're serious about attacking the debt and the deficit, why do you give a tax break? And if you give a tax break, why don't you give a tax break that really affects the ordinary working people, the blue collar people in our

society, that is, take five points off the PST, something like that?

Why, if you're really interested in the debt, would you close halfway houses, which are bending over backwards to perform such a significant service to our society, and put the people into jails where the costs are three times what they are in halfway houses?

The other thing about this process, the unfairness of it—I've heard Ms Johns here speak about amendments they've contemplated. I've got my presentation here. I'm not sure I'm not going to be speaking about some of these things that are already supposedly amended. How much of what I'm going to say has already been addressed? And maybe the way it's been addressed is something I'd like to comment on too.

Mr Carroll, I want to say that however you were chosen for the chairmanship of this committee, I think it was a lucky break. But I want to emphasize to you that during the election on June 8 the mandate you received as an individual represented one third of the community, so we can't do things in too heavy-handed a manner.

I want to speak about some of the merits of the health issues in this Bill 26. Of course, you've heard these from other things.

The increased power of the minister: Ms Johns has told us that the minister is not going to have the discretion that the bill suggests the minister's going to have. The minister is going to be acting like some sort of czar. The worst thing about Bill 26, the very worst thing, is the process involved in it and the fact that there are so many things in it that say, "And there shall be no appeal from this process."

We live in a democracy where everything is appealable. That's why we have an ombudsman, that's why we have several levels of courts where we can launch appeals. In labour management we have the arbitration procedure. Everybody has appeals. Is it such a horrible thing to appeal a minister's decision?

Let us put it in these very succinct terms: If the bill went through as it had been proposed, without these amendments—they are now clearly acknowledged as mistakes and they're going to be amended—what would the appeal have been to that? It would have been the regular parliamentary process where you get in there and you debate and so on and you get chippy with one another, but the point is that society is not served with that type of approach.

The repeal of present laws which is going to make it easy for American health caregivers to come to Ontario: As I said, I've been on every continent. I go to the United States every year. One of the things people talk to me about once they find out I'm a Canadian—they see it on my licence plate. If I'm in a coffee shop waiting for my truck or car to be serviced, they say, "Oh, you're from Canada, eh?" Well, that "eh" is Canadian. I say to them, "Yes, I am from Canada," and they say, "Could you tell me about how your health system works?"

They don't ask me about Trudeau, they don't ask me about hockey, they don't ask me about Molson Blue or Baywatch; they ask me about our health care system. They say, "My wife's on medication and my daughter's on medication, and \$200 off the top of what we earn has

to go for health care." Professors who are my colleagues in the States say that in their collective agreements there's a figure of \$4,000 to \$6,000 per year on top of their salary that's required for the health care system. They're really interested in it.

Ralph Nader came to Ottawa a few months ago and gave a very illuminating talk on how the 10 top CEOs in the health care business in the United States control billions of dollars of assets and take millions of dollars of salary. You can't say Ontario is in that position. Yes, we went through a period of escalating costs. I think, though, that responsible people have tried to bring those costs under control and have done a good job.

I can understand the minister's frustration with the hospital restructuring system. We've got a system right here in Sudbury where we've gone through a process of over two and a half years to get our hospital system restructured. It's a difficult process. We can't agree on it. Yes, there are some people who say it's time for a minister to come in and use arbitrary powers. That's a short-term solution. The long-term solution is solutions that are determined by the people themselves and by the solutions the people buy into.

The role of district health councils: What is the role of district health councils going to be under Bill 26? Traditionally, the labour council has a representative on the district health council. That's one of our most important appointments. We monitor that very closely. Every month we have our representative report to us in detail what's going on in the health council. What touches the lives of working people more than their health? That's a very important consideration.

Section 8 of this bill does not mention health councils. That has to be addressed. We have to have some sort of firm indication of what's going to happen to these advisory councils we have that perform yeoman service and do it for nothing. In fact, in Sudbury they do it for more abuse than compliments.

What about the amendments concerning funding? Bill 26 gives the minister virtually unlimited power to dictate every detail of hospitals, including funding, operation, closure and amalgamation of public hospitals. Is that part of the democratic process? Do we want to assign a responsibility like that to an individual?

I don't know if this is going over the same ground Ms Johns spoke about, but the power of the cabinet to appoint investigators under the Public Hospitals Act: What are these investigators allowed to view? Do they have access to this confidential material? Has that been addressed?

When I read Bill 26, I'll tell you, it's such exciting reading that when I go to bed and I take it up I don't get to sleep till about 4 o'clock, because I see things in here which really bother me, and they bother me because it's not in the tradition of Ontario society to give such unfettered discretion to people.

Our society is built on checks and balances. It's part of the trade union movement, for example. They often libel us by saying that we're autocrats and dictators and so on, yet every collective agreement is signed according to a mutual acceptance by management and by labour. There's no coercion involved in there, and when you hear people denigrating the labour movement because they've got

such strong collective agreements, why don't you look at the management side? Why don't you say that you didn't have the appropriate people in management negotiating those contracts, because they were freely arrived at?

What is this business about negotiating directly with doctors that your government has proposed instead of going through the OMA, directly dealing with individual doctors? The present government has a self-interest organization. It's called the Progressive Conservatives. Some of you are professional people. You belong to common interest and self-interest groups, whether it's the chamber of commerce or the Canadian Labour Congress or what have you.

This is something that is part of the democratic feature of our society, that we have groups that speak for us and that you don't seek out individuals. For example, in a unionized workplace, if you negotiated directly with the unionized members, there's grounds for an action against the employer under the Labour Relations Act, even under your act, Bill 7.

1050

The cost of drugs to seniors and retirees: The people, such as my father came to Canada as an immigrant and settled in Hearst and got some government property there which he could get title to if he cleared so many acres in two years—he came from a relatively warm part of Europe to a very cold part of Ontario—are the people who are now the seniors and the retirees. Why should we penalize them? As a society, I think we have an obligation to these people who carved out of the wilderness a very progressive society.

If you don't believe me, go to some of the countries I lived in. I've been in cities like Karachi, Pakistan, for example. I was there for the first time about 30 years ago. I counted 30 beggars per lineal mile and I said to myself, thank God that's not Ontario. Walk down Yonge Street now. Ontario is turning that way. We've got real problems. We're not going to address those problems if we don't do it in a practical, pragmatic, upfront way.

I'm going to leave the balance of my submission to the written submission I'm going to mail you. I certainly won't fax it, because it'll probably be about 209 pages, as compared to your 211-page bill. I want to thank you very much for being patient with me. I want to reiterate again how significant is the work that you're doing, and you can put a real mark on the way in which democracy is evolving in this province if you do listen to the people and you start to show the same sensitivity that your colleagues showed and were in power for 42 years in the not-so-distant history.

The Chair: Thank you. We've got two and a half minutes per party, beginning with the New Democrats.

Ms Martel: Mr Filo, I want to look at some of the arbitrary and increased powers the minister brings on to himself under this act and ask you to comment on them.

Firstly, in the new section 6, the minister is given the power to close hospitals, to order amalgamations or to specify the services that are to be delivered in that hospital if the minister deems it to be in the public interest. Of course, he has the power to do that unilaterally. What do you think about that power being granted to a minister who sits in Queen's Park in Toronto with

respect to hospitals in northern Ontario?

Mr Filo: If I were the minister, I would say, "I do not want that power." I would say that the ability to do all these things should be granted to the people who are on the front lines, who actually work with those institutions, who know the community they serve and are professionally committed to be publicly accountable for all their actions. If I were the minister, I would say, regretfully, that I would not accept that power or responsibility.

Ms Martel: The minister not only takes that power unto himself, but in a different section, for example, in section 9, there are some pretty extraordinary increased powers that are then given to a supervisor to deal with the operation of a hospital. The supervisor can go in, the board can be removed, and without any public consultation that supervisor, at the behest of the minister, can take on the day-to-day operations of that hospital.

We know that people in this community, on the boards in all the hospitals, work for free. They do a tremendous job. Why do you think we should be allowing a supervisor, who will probably also come out of Queen's Park in Toronto, to come and start running hospitals on our behalf, without any kind of public input or public consultation from the communities at stake?

Mr Filo: I'm in the education business and we have a saying that we should not play God with our students. Ministers should not play God with the citizens of this province. That type of power: It was in 1215 when society first recognized that you have to take absolute power away from a person. Everybody looks back and cheers how the Magna Carta took some of the power away from King John and shared it among his barons. That was the evolution of British parliamentary democracy. We can't look at those things very lightly. The sharing of power, the use of other people in making joint decisions, in making collaborative decisions, are part and parcel of the way in which this province should continue to work, and so I would say that no minister should have those unfettered powers.

Mrs Ecker: Thank you very much, sir, for a very excellent presentation. You are extremely well informed and we look forward to your written submission. As you know, many people have chosen to do written submissions and we certainly want to encourage that, because the input that we're receiving is very helpful.

You put your finger on the point, though, when you said that we do have problems in this province. They didn't happen overnight; they've been growing for many years. You put your finger on one of the difficulties. As you say, individuals have learned that they have to live within their means, and I think that one of the difficulties is that government is kind of late to that philosophy. That is one thing we're trying very hard to fix so that we can get off the back of working people, who have been carrying a fairly high tax load, so we can try and give them some break here.

The other thing I would like to say is that, just to address the issue of patient confidentiality, as you probably know, information within the health care system about patient records, with or without patient names, frequently, when they can, is currently being shared for

fraud and misuse investigations, for judgements that are made about the effectiveness of treatments, for research into what works and what doesn't, and for better management of the system.

That's the intent of any information sharing that is going to be going on in the health care system. If there are difficulties or questions or concerns that this may not indeed be happening, that there need to be more checks and balances in the system, because again, as I'm sure you're aware, there are many checks and balances on confidentiality for use by professionals and the minister within the system, but if that needs to be clarified further, we've indicated our willingness to do that.

I think it would be very wrong for us to come out and release our opinion of how we think changes should be made before we've given everyone else who's coming in and presenting, like yourself, an opportunity to put forward suggestions or put forward their written submissions, so I think that's important to make clear.

The other point you raised is that many groups speak out on behalf of individuals. Political parties, which you're familiar with, speak out on behalf of individuals. The OMA will be continuing to speak out of behalf of physicians. That is the way we would like to see that happen.

Mr Frank Miclash (Kenora): John, I too very much enjoyed your presentation. I think we in northern Ontario are very fortunate to have you, and your views, as a resident of northern Ontario.

You spoke about consultation. A question I've been asking a good number of presenters as we've gone along is whether they, or any group or organization they know of, were consulted during the drafting of Bill 26.

Mr Filo: No, I don't know of any organization that was consulted. It's the same as the other bill, the bill that is nearest and dearest to my heart, Bill 7. It would have been, I think, appropriate to have had consultation with the trade union movement, simply because when you start a football game, for example, the umpire flips a coin but it's decided ahead of time which one is going to make the call and people are given an opportunity to be part of the process. Yet here we have very specialized legislation coming out where the real experts who live and work and breathe the articles in this legislation have not been consulted, maybe in fact have been studiously avoided, in the process of getting a bill out like this.

Mr Bartolucci: John, thank you. Our leader thanks you for your presentation as well. She had to leave.

I'd like to follow up with regard to the commission and the DHC. Certainly, if the commission is to be successful, there must be clearly defined roles and responsibilities of the commission and the DHC, and obviously that's not outlined in Bill 26. Maybe because the government is listening so well, you might want to give them an amendment they might use. What type of regional mechanism should exist within the commission to interface directly with the local DHC to facilitate hospital restructuring?

Mr Filo: The commission should be a locally appointed commission and should probably be what the area here has experimented with over the past half a dozen years, and that's called the interlocking board—representatives

from all the hospitals, people with a stake in the community and the health care system—to reach some sort of consensus and then carry out their decisions. That's the way in which the commission should be structured.

The Chair: Thank you very much, sir. We appreciate your attendance here this morning and we look forward to your written submission.

Mr Filo: Mr Carroll, I wish you good luck. I hope you do become a footnote in history and one that is gilded.

The Chair: I'm still trying to figure out exactly what your previous comment meant about my selection as Chair, but I'll work on that one.

Mr Bartolucci: If he was paying you a compliment, Mr Chair, you would have known.

The Chair: As the next group, the health care coalition, is coming forward, out of necessity the Chair is going to set a precedent and take a two-minute recess.

The committee recessed from 1102 to 1111.

The Chair: I knew I would set a dangerous precedent; I've lost most of the committee. However, we will get back to work. We actually have no time left to eat today, so I'm not sure what we're going to do with that.

COALITION OF HEALTH CARE WORKERS

The Chair: We have the Coalition of Health Care Workers, represented by Jan Hibi-LeBlanc. I hope I didn't butcher your name too badly. Welcome to our committee. You have a half-hour to use. Questions will start with the government. The floor is yours.

Ms Jan Hibi-LeBlanc: Thank you. Ladies and gentlemen, my name is Jan Hibi-LeBlanc, and you didn't butcher my name too badly. I'm a lab technologist at the Sudbury General Hospital, where I've served this community for the past 20 years. I represent the Coalition of Health Care Workers, a group of community labour leaders with both the Ontario Public Service Employees Union and the Canadian Union of Public Employees. This group is particularly interested and involved in the restructuring of health care in Sudbury.

I will begin today by reading a passage from Maude Barlow and Ken Campbell's book, *Straight Through the Heart*. It describes a fundamental principle held dear to all Canadians, a principle violated by Bill 26:

"Democracy presumes that power, the capacity to impose one's will, rests ultimately with the people. People delegate power, through the politicians they elect, to a sovereign state to pursue common ends. Democracy presupposes a sovereign state that sets priorities and policies reflecting these common ends. Without state sovereignty, democracy is hollow; without democracy, state sovereignty is tyranny. Democracy is all about inclusion, people being connected to one another and to the political leaders in their community. Democracy is about having people having confidence that the politicians whom they vote into office will act on their behalf. Democracy is about accountability and trust."

Bill 26 is a direct violation of that trust. This government shows its total disdain for the people of Ontario by voiding the very premise of accountability in three ways.

The first is through the repeated use of the no-respon-

sibility clauses throughout the bill, protecting the government from all legal challenge and denying the right to appeal. Not only does this government place itself above the law, but it imposes a dictatorial leadership which screams, "My way or no way." This government is attempting to grant itself total immunity, an absolution from all actions.

Laboratory technologists are a regulated profession. This means I am personally responsible for all job-related actions. This means I take full responsibility for my work in ethical, moral and legal terms. As a local president, I am responsible to the members I represent. The Premier and his ministers are public service employees in that they are paid with public dollars, and they should be as culpable as any in this province for the work they perform in their jobs.

The second insult is the amendment to the Freedom of Information and Protection of Privacy Act. The availability of information is an essential pillar of democracy. Restricting information about the workings of our government, public institutions or the use of public funds smacks of Iron Curtain mentality.

Members of the health care coalition also participate in the fiscal advisory or operational planning committees of our respective hospitals. Although our participation has been limited, we see our role as that of the community watchdog. We believe it is important to ensure that our administrations and boards are accountable to the community. The current legislation regulating access to information is still restrictive but it is a fair system.

To restrict the access by allowing the head of an institution the power to dismiss the access using terminology as vague as "frivolous or vexatious" is admitting to the destructive empowerment of the haves and the belittlement of the have-nots. Restricting access to information implies a need to cover up or hide, which in turn implies side deals and payoffs.

The third disregard for public accountability is one of the changes proposed to the Independent Health Facilities Act where the minister may direct requests for establishing independent health facilities to specified persons rather than through public calls for tenders. This sounds like a legalized old boys' club, a haven for corporate buddies with no liability.

Bill 26 substantiates the fear that Mr Harris in his haste to promote his corporate agenda will privatize our health care system. Removing the requirement to give preference to non-profit Canadian operators of independent health facilities and allowing the Minister of Health to handpick corporations or individuals to open these facilities, with no appeal rights, opens the door to the American corporations.

The bill allows the minister to designate new types of health facilities or services and potentially could allow the minister to determine who will be allowed to provide the services. The bill paves the way to user fees and extra billings. It is apparent that the Conservative Party believes in a corporate-controlled class system, a two-tier Ontario where accessible universal health care no longer exists.

Health care workers have long supported the premise and the need for restructuring. We have attempted to

discuss centralizing services, multilayered bureaucracy, to no avail. The empire-building has grown to phenomenal proportions, catapulting us into this mess where the only escape the bureaucrats can visualize is to gut what took generations to build. We can only hope that some members of the Conservative Party will have enough national pride to stop the sale of our Canadian health care to the US by voting down at least this part of the bill.

Mr Harris has gone one step further in his bid to assure maximum profits for his business associates by neutering the interest arbitration process. Since essential service employees, such as hospital workers, cannot engage in free collective bargaining, compulsory interest arbitration determines the terms and conditions under which we work. Arbitrators have stated that basing an award on ability to pay could render the arbitration process largely irrelevant since the use of ability to pay could allow the government and employers to unilaterally determine wages and benefits by simply allocating a fixed or reduced amount for employee compensation in their transfer payments or budgets.

This bill also appears to empower the cabinet or the ministers to make regulations which could override the provisions of contractual agreements. These are blatant displays of the contempt this party has for the working person.

The most frightening clause appears under the minister's authority to disclose health information. We will be living George Orwell's Nineteen Eighty-four. Big Brother will be watching.

This clause is without a doubt the reason the government is attempting to ram this bill through with lightening speed, because even if the average Ontario resident has no understanding of any part of this legislation, they would understand the implications of this section.

Mr Harris's buddies in business must be wringing their hands in anticipation of achieving the power to legally access personal information, including medical data, to use for screening out job applicants or getting rid of employees. The relationship between doctor and patient will be drastically altered. With no right to privacy, the trust is gone. Patients will hesitate to provide physicians with vital information or will refuse to seek medical attention.

Does this open the door to a brand-new private sector enterprise? An agency delegated by the ministry to search out and sell this type of information? How unbelievable that a Canadian governing body should even consider this change.

I have barely touched on the indignities this bill heaps on the people of Ontario. The ministry person who contacted me for the hearings asked if I was going to discuss labour adjustment. The government has allowed no forum for such discussion. The public sector workers are losing their livelihood and the government is so unconcerned that it has not even studied the impact these layoffs will have on our communities.

This government has no redeployment strategies; in fact, HSTAP, the health sector training and adjustment program, which is the system originally put in place to help retrain and redeploy hospital workers in a central job registry, is in jeopardy. Mr Harris has painted the public

sector worker as public enemy number one, creating public acceptance that we are disposable. We provide valuable service to our community and we contribute to our local economy.

A government which believes it should merge or close health care facilities without hearings, or dictate to and overrule community boards, has assumed a fascist label. We have hope that communities will exert pressure on their duly elected representatives to defeat Bill 26.

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The Chair: Thank you. You've allowed about five minutes per party for questions, beginning with the government.

Mr Clement: Thank you for your presentation. It will come as no surprise to you that I disagree with your characterization of us as fascists. Certainly as someone who has had relatives who have been victims of fascism, I actually take that as a personal affront, but I'm sure you really didn't mean it that way.

Let me just get to the substance of what you had to say, though, because I don't think we're here to do name-calling necessarily, and I'm sure you didn't mean it in that way. I want to zero in on a couple of things you said, first of all with respect to the disclosure of health information. Other members of the committee, please forgive me for going over some old ground, but this is the first time we've been in Sudbury.

When I read the old legislation and when I read the new legislation, the new legislation under Bill 26, under disclosure of information, has conditions under which information will be disclosed. The old legislation has no conditions. It just says it will be deemed to be disclosed. Have you read the old and new acts? Then you'll know that the old legislation is more general, more sweeping, less constraining on government, on Big Brother, than the new legislation. If you have read the legislation as I have, do you have a different interpretation and can you back that up with any form of interpretation that is valid?

Ms Hibi-LeBlanc: I believe the interpretation comes when you view the bill as a whole. When I sat down and read Bill 26 and took it as an overall document, the overall document supports that this government is about to take over the system in a complete and total way, with no liability. In that respect, I view this mention in the amendment as a way of gaining control over my personal medical information to use within the corporate system.

Mr Clement: If that was the logical result then I would share your concern, but as I say, I've actually read the legislation and I'm sticking to my interpretation of it.

With respect to independent health facilities, you see this as a real threat, but I've got a constituent in my riding who would love to set up an independent health facility to relieve pressure on our hospital. He's saying: "Look, they've got a lineup of two years for hand surgery. I'd love to perform the hand surgery and relieve some pressure on the hospital so you can get quality care at the hospital with less of a wait and quality care from me."

He's requested that power from the local authorities for years, through a request for proposal, and nothing ever gets done. He's eagerly anticipating the ability for someone in the system who cares about waiting lists and

waiting queues, namely, the Minister of Health, to break the logjam and get some quality care in my community. Is he wrong to see the legislation that way?

Ms Hibi-LeBlanc: I don't think he is, but look at the way they've set up the act: by removing one clause, they're not just allowing a physician or a health care provider to open up a new independent health facility; what they've done is they've opened the door to the Americans and that is by far our largest objection.

Mr Clement: Let me ask as a consumer of health in our province, and I'm not trying to be provocative here, but if an American or an Italian or a Taiwanese can offer better services at a lower cost, what's wrong with that?

Ms Hibi-LeBlanc: First of all, because I am Canadian and I believe we should be supporting Canadian business.

Mr Clement: Go to the Canadian business then. You don't have to go to the Taiwanese business if you don't want to, but if I want to get the best cost for my family and my children for the system, what's wrong with that?

Ms Hibi-LeBlanc: The problem is we are now talking not only about opening up an independent health facility, but we are also talking about for-profit health care, which doesn't go hand in hand with universal, accessible health care in this province. We're talking about people who can afford to pay Americans for services that Canadians could provide in a non-profit setting.

If you look at the suggestions that have come forward just from this city alone, the Dr Bonins over at Laurentian Hospital have put forward a proposal, and I'm sure you're aware of it, where they have offered a suggestion to offer laboratory services at 75% of the cost of the services that are provided by private laboratories. That means 25% less—

Mr Clement: That's great.

Ms Hibi-LeBlanc: —but it has been turned down, and as far as I know they're still in the courts—

Mr Clement: But not by this government, it hasn't been turned down.

Interjection: Clearly by your government.

Mr Clement: We'll have to get clarification on that.

Mr Miclash: Just to follow-up on Mr Clement's comments, I would suggest that he read *A Voice for the North*. It's the Report of the Mike Harris Northern Focus tour, January 1995. This was the document that was floated around in June during the campaign and in it Mr Harris states: "We need answers—not made-in-Toronto policies, but solutions based on input and ideas from people who live and work in the north." This is a statement made by the present Premier of the province.

Could you tell us if you know of, or whether you were involved in, the draft of Bill 26 or know of any group that was involved in the draft of Bill 26?

Ms Hibi-LeBlanc: You must be joking.

Mr Miclash: This is the thing I get to. Mr Clement, as I indicated, should read this document—

Mr Clement: As a point of order, Mr Chair: I have read this document.

Mr Miclash: Then I would suggest you tell your Premier the commitments he made to people in northern Ontario.

Mr Clement: That's why we're here.

Mr Miclash: And we wouldn't be here unless we sat

in the Legislature for 24 hours as well.

Mr Clement: That is absolutely incorrect and I refuse to have that on the record.

Mr Miclash: That's right. You would be in Toronto right now. These people wouldn't be here.

The Chair: A five-minute recess.

The committee recessed from 1128 to 1132.

The Chair: Mr Miclash.

Mr Miclash: I'd like to continue, and as I was indicating before the little ruckus, we have *A Voice for the North*. This document was waved in my face as a candidate in my riding by the Conservative candidate. It goes on to say, "The people of northern Ontario have given us a clear message: Their needs and concerns are not being met by the provincial government."

Again, Jan, I ask you: Do you think your needs and your concerns were being addressed in the drafting of that bill?

Ms Hibi-LeBlanc: Shall I answer you as a health care worker or as a northerner? As a health care worker my needs have been totally disregarded. In fact, we are blatantly stepped on. We are almost spit upon.

When I read Bill 26 I felt I should move. I started looking at Kuwait or Saudi Arabia because those are good places for lab technologists right now, because Ontario, frankly, is becoming a community or an area that I am wondering if I really want to live in.

Mr Bartolucci: Thank you very much for your presentation. Again, I apologize for the dust-up, as we call it. But you know, in fact, we must ensure that the truth is made known. It's very essential that you advise the government so that they can bring their recommendations back to cabinet.

Do you advise the government to delay passage of this bill to allow for further hearings to take place so that all aspects of Ontario can be listened to and the government can hear and digest what people like you are saying?

Ms Hibi-LeBlanc: Of course I do. When I found out I had standing room, which was Thursday night, I didn't know if I should feel honoured, fortunate or in big trouble, because I realized that there would be very few people or very few groups that would be allowed to speak. I also wondered about the process in choosing the people who would speak at this hearing; how was my group selected?

In that respect, I think it is unheard of in our democratic society that the public should not have a say in how our province is going to be run, and in that respect they should be running hearings on a bill as onerous as Bill 26 for the next year before they even consider bringing it forward.

Mr Bartolucci: One health-related question: Are these amendments going to lead to a two-tier health system?

Ms Hibi-LeBlanc: Undoubtedly. As soon as you have to pay for health care you have, as I said, the haves and the have-nots. If I can't afford to pay, it'll be a system where you have the rich, who will feel very well, and the poor are not going to feel well at all.

Ms Martel: There are two points that I'd like to make first before I ask you the question, Jan.

First of all, let us all be clear in this room that we

wouldn't be here today having this public hearing in Sudbury, Ontario, were it not for the fact that the Liberals and the New Democrats together stayed overnight and forced the hand of this government. This government wanted this bill rammed through before Christmas without public hearings anywhere outside of Metropolitan Toronto, and let us not forget that is the case.

The second point I want to make is that we now have over 53 groups that have requested standing in this community to make presentations, because people in this community are so concerned. We only have room for 13, and our party has moved a motion which will be debated over lunch to have those hearings extended. So any of you who are concerned about getting on and want to be heard and think that this should have some broader coverage than it has to date, I encourage you to stick around and listen to that debate.

Jan, I just want to talk to you about one point, and that is your concern about accountability and how this government doesn't have any accountability via this bill, in contrast to you as a health care worker and all of the checks and balances that come into play when you do your work. Time and again in the legislation, when the Minister of Health gives himself increased, unilateral, arbitrary powers, he says he is doing that "in the public interest," yet at the same time in almost every case, the government, also in the same section, makes sure that it is immune, that it will not be subject to any legal action.

Do you really feel convinced that what the government is going to do is in the public interest if, after every section of what it does, it's also protecting itself from any court challenge?

Ms Hibi-LeBlanc: That's an interesting question. I think it was on January 1, 1994, that my profession was regulated by the government. So the government told me on January 1, 1994, that I am responsible totally for every tiny item I do at work. I can be taken to court, and all that has to happen is one person lodging a complaint with my college and I'm suspended. That means I can't work. I am completely culpable for anything I do, and even if it's hearsay, even if it's just a patient complaining that he didn't like the way I looked at him that morning, I'm done until I can prove myself innocent.

This government has decided that even though I am going to be controlled as a worker and that I am watching everything I do, they don't have to watch a single, solitary thing they do. They can just go along and make any decision they want to that will affect thousands and thousands of lives and not be held responsible for it.

The Chair: Thank you for your presentation. I apologize for the ruckus that went on, but we appreciate your input here this morning.

I remind the audience—some of you weren't here first thing this morning—that dialogue is between the presenter and the people at the table. You're certainly welcome to listen. You're not welcome to participate.

MIGUEL BONIN

ROSEMARY CHRISTINCK

The Chair: The next group is a group of residents from family medicine. Welcome to our committee. You

have a half-hour to use as you see fit. Questions will begin with the Liberals, at the end. The floor's yours. Identify yourselves so that Hansard has a record, please.

Dr Miguel Bonin: Thank you, Mr Chair, committee members, for allowing us to meet with you today. I am Dr Miguel Bonin—not to be mistaken with the pathologist in town, a different Dr Bonin—co-chief resident for the northeastern Ontario family medicine program. I'm accompanied by Dr Rosemary Christinck, my co-chief resident at NOFM, and Dr Julie Auger, a first-year family medicine resident.

We are here today on behalf of 26 of 27 family medicine residents presently completing their post-graduate training with the northeastern Ontario family medicine program in Sudbury, also known as NOFM. All of us are eligible to set up independent primary care practice within the next 18 months, half of us within six months.

We are a select group of physicians who have already, at this early point in our careers, made a commitment to northern and rural health care in this province. In so doing, we have been blessed with the opportunity to be in daily contact with both patients and physicians presently living in medically underserved areas. Therefore, we believe that as a group we can give a relevant, firsthand opinion of the medical underservicing problem as it relates to northern Ontario.

Indeed, I am a native of Sudbury, while Dr Christinck comes from rural Ottawa Valley and Dr Auger hails from Sturgeon Falls. We therefore feel that we can speak for northern and rural parts of this province, not only as providers but also as consumers. During our training in northeastern Ontario, since leaving the major university centres where we trained, we have spent time in communities from Huntsville to the south, Hearst to the north, Mattawa to the east, Sault Ste Marie to the west and all points in between.

As a group of 26 physicians presently training in the north and most likely to participate in the solution of the underservice problem, we have major concerns with the steps proposed within Bill 26 to try and solve the medical underservice problem. Our futures are being decided, with little debate, by people who know little about us and know little about what northerners want from their health care providers.

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The attempt to restrict access to billing numbers by linking access to specific geographic areas is deplorable. We can no longer remain silent in this debate, and as a group of young physicians as yet unconsulted, we have drafted this presentation so that the northern voice can finally be heard. Let me reassure you that we do not wish to be confrontational and simply reject the steps taken in this bill. Rather, we would like to present realistic northern alternatives which in our opinion may finally work.

Some background information. Over the past three decades many projects have been suggested and a few have been implemented in an attempt to solve the long-standing problem of underservicing of medical practitioners in rural and northern regions of Ontario. During that time, almost two generations of physicians have graduated from our medical schools, but the same unders-

ervice problem persists. Indeed, similar problems exist in most regions of this country, as well as rural parts of the United States and Europe. This is probably due to the fact that public authorities rarely, if ever, consult the people of these regions as to their proposed solutions.

Presently in Ontario, the newly elected government has committed itself to solving the underservice medical care problem, and it should be applauded for this. Two reports, *Small/Rural Hospital Emergency Department Physician Service*, by Graham Scott, and *Equitable Health Human Resource Distribution: Fulfilling Underserved Area Needs*, by PCCCAR, are often quoted, but by nature such reports are lengthy, idealistic and for the most part unattainable unless implemented in their entirety. Considering the present fiscal realities, this is unlikely to happen. Some of the points that we will be making shortly are contained in these reports but in our opinion have not received adequate attention from authorities.

In a letter to physicians dated November 22, 1995, the present Minister of Health stated, "I am committed to immediately resolving this long-standing problem." This would be ideal, but is unlikely, since Band-Aid solutions such as the ones proposed have been unable to properly solve this chronic problem. We would rather see leadership make statements and take action that would immediately give northern and rural players the tools to finally resolve this problem adequately. We do forewarn that a quick fix does not exist. Rather, a long-term strategy, coupled with short-term measures, may prove to be more beneficial and cost-effective.

Our recommendations:

(1) Geographic billing numbers: As a group of young northern physicians likely to be most affected by the proposed restrictions on billing numbers to certain geographic areas, we simply cannot accept this alternative as a realistic solution to underservice of medical care. It is our contention that such a proposal infringes on our rights and freedoms as put forward by Canadian law. Also, we believe that coercive methods would probably lead to poor work output by the affected physicians. In medicine, as in other fields, unhappy workers are usually less productive than satisfied workers. In the end, those who would be affected the most are, of course, the consumers. Northerners deserve better.

Let us also remind you that physicians have to consider their families prior to making career decisions. Spousal employment has been identified through studies in the north as a major barrier to recruitment and retention in this part of the province. Forcing physicians to come here if their families cannot follow them will lead to the loss of this physician permanently.

We recommend that restrictions on billing numbers be abandoned as an alternative and that any mention of such measures be permanently removed from this bill. Reassurances that the present Minister of Health will not proclaim the relevant sections of the act are not enough. Future elected representatives may act on the threat if the powers to do so are in place. Indeed, this minister has already indicated he might do that.

As you heard in Timmins yesterday, this contentious issue is forcing all physicians, young and old, to re-evaluate their futures in this province. This is not only

the case in larger centres but is also being seen in rural settings. In trying to solve the medical underservice problem, this government may be contributing to it with this and other measures contained in this legislation.

If geographic billing number restriction is not the answer, what is? The following suggestions are our recommendations to properly solve the medical underservice problem.

(2) Properly define "overserved" and "underserved": In order to find an appropriate and long-lasting answer to the medical underservice problem, we believe independent third parties should survey all regions of Ontario to properly define areas of either absolute need for health care or relative need in specific areas of health care, as suggested by the PCCCAR report. This would allow for databases to be updated and therefore become more meaningful. This study should also note which regions are overserved in general but may contain specific underserved populations in need of additional medical service, ie, care of the elderly, aboriginals, francophones, women.

Ici, dans le nord-est ontarien, nous faisons souvent face à des situations où les francophones ne peuvent pas être soignés par des médecins de famille ou, plus souvent, des spécialistes francophones. Le cas est pareil pour les aînés, les autochtones et les femmes dans le nord-est, ainsi que dans la province toute entière.

In a sense, the underserved area program should be totally overhauled and should receive a fresh mandate. As stated earlier, 25 years of the present format has not fully resolved the problem and we believe the time has come for a new vision to prevail. If this problem is not properly defined or understood, it cannot be properly solved.

(3) Long-term solution: Ultimately, we hope that the problem of medical underservice will be permanently solved. This will not happen overnight as is the hope of this government. The following proposals are designed to eradicate this problem permanently.

Our suggestions for the long-term resolution of this dilemma are twofold. Firstly, more northerners and citizens of rural Ontario need to be recruited into medical training. This can be done by high school education and recruitment tours. We refer to the University of Ottawa's past and present recruitment policy for francophone medical trainees.

Local sponsorship of candidates by their respective communities may also be a possibility and is increasingly being discussed by northern leaders in order to ensure appropriate access to medical education for their youth, their future. Let us remind you once again that it is well documented that northerners are much more likely to practise in the north on a long-term basis than southerners may be.

Secondly, pre-medical, medical, post-medical and continuing medical education must increasingly be made available in northern and rural Ontario. Physicians are more likely to practise in communities where they have completed their medical training. Examples of recent successes are NOMP in Thunder Bay and NOFM in Sudbury. The latter program's northern and rural retention rate after only five years of existence is reported to be 70%. This is much better than any previous training

program in the province. Also, one must recognize that geographic and professional isolation accentuates the difficulties of trying to stay up to date in the ever-changing world of modern medicine. This must be recognized.

Obviously, these recommendations will not lead to rapid results but may in the long run be the most cost-effective. Leaders must realize that physician supply cannot be quickly controlled as is water flow out of a faucet. On average, it takes nine to 12 years of post-secondary education to train physicians. The benefits of admission policy changes made today will only be seen some time in the next century. Regardless, we believe that this option is not receiving its fair share of consideration in public forums addressing the maldistribution problem. As northerners, we see this problem and its solutions from a different perspective.

(4) Short-term solutions: Once again, coercion and billing number restrictions are not acceptable or realistic solutions for the reasons listed earlier. An acceptable short-term solution would be to consider the application of fee differentials to properly defined service discrepancies. In keeping with the theme of the Common Sense Revolution, we believe the solution should be financed within the government's present budgetary allocations. Unfortunately, recommendations within government-sponsored commissions often do not address the financing of their recommendations. We would like to do otherwise.

Disincentive payment schemes for physicians working in properly defined overserved areas should be used to finance incentives in underserved areas. For example, a 1% reduction in payments to physicians in properly defined overserved areas—the majority of the physician pool—would generate a large sum of money to finance the solution in underserved areas.

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These funds could be used to finance a 1% to 5% increase in payments to all physicians in properly defined underserved areas; to fund continuing medical education programs in properly defined underserved areas; and/or to fund efficient locum programs to provide for respite time for physicians in areas with limited medical support systems, such as is the case in northeastern Ontario. Indeed, this could be looked upon as an isolation package of sorts, which is often seen in the private sector.

Because of population discrepancies, a 1% premium on health care dollars spent in the greater Toronto area would generate a significant pool of funds to finance programs in northeastern Ontario as suggested above and by the Scott and PCCCAR reports. Indeed, the medical profession has finally realized the merits of such a fund to address the medical underservice problem and is proposing this at this time.

The premium could slowly be adjusted to appropriately control the flow of physicians, ie, increase or decrease the overserved disincentives or underserved incentives as required. It could also be stipulated that physicians in properly defined overserved areas could avoid paying the premium by committing time and service, two to four weeks, in a properly defined northern or rural underserved area through a structured respite locum program. During their time in the underserved area, they would

receive billing amounts appreciable to that region, 101% to 105%, minus reasonable overhead costs.

We want to stress that the numbers used in this description serve only to illustrate a case and may need to be progressively adjusted in order to reflect the realities of the day. No one knows what the appropriate disincentive value needs to be to solve this problem, but realistic remuneration will also have to be maintained in larger centres.

(5) All physicians should be affected equally: As a group of young northern physicians, imminent graduates, we believe that all physicians should be part of the solution in an equal fashion. We, as young physicians, have not created the medical underservice problem nor the existing health care budget shortfalls. Regardless of this fact, we want to and must be part of the solution. Previous negotiations in other jurisdictions have seen government and medical associations transfer the bulk of financial burdens and legislated solutions onto the next generation of physicians.

We believe, as does CAIR, the Canadian Association of Interns and Residents, that all physicians should provide the same level of care and should shoulder the burdens on an equal footing to prevent the overburdening of the future of health care in this province.

In summary, we, as northern health care providers, believe that these solutions are realistic and in keeping with the will of northerners who have a vested interest in this problem. They are not the only possibilities, but they are our best recommendations. Any action taken by the government should affect all physicians equally, regardless of age or year of graduation. We reiterate, once again, that we, as young physicians, did not create the problem but wish to be part of the solving process.

Give northerners the tools they need and have been asking for in order for us to deal with this problem, which we truly understand, since we face it every day. Physicians, bureaucrats and politicians cannot solve this problem from their offices in Toronto. This bill, with its theme of centralization of power, goes against everything northerners have requested over the years.

We would also ask for a quick decision on the fate of our access to billing numbers in July 1996 since all of us must make the necessary plans to set up our practices. Many small northern communities are anxious to receive our answers. For the moment, given the present turmoil, we are unable to make any commitments as to our own futures. One thing is certain, with the passing of every day, this province is losing young physicians who can no longer envision practising medicine in such instability and coercive situations. The investment made in their education is forever lost to the people of this province.

In addition, future generations of physicians, medical students and junior residents, need to have a long-term predictable vision of what practising medicine in Ontario will be like. The annual indecisiveness, turmoil and threats surrounding licence acquisition in this province cannot be allowed to continue.

The Chair: We have about two minutes per party left for questions, beginning with the Liberals.

Mr Bartolucci: You say that the Sudbury family

medicine program has a retention rate of about 70%, yet you mention that we are losing young physicians daily. Is it a morale problem, or what explains the statement you made with regard to our losing physicians?

Dr Rosemary Christinck: The program we are in is unique in that it does retain approximately 70% of its residents. That's very unique in all of Ontario. We are losing many physicians, partly from Timmins, which we heard yesterday on the news—also from larger centres—and that will decrease the resources we have to supply the north.

The feeling we have received when we've gone through our training program is initially we were given the promise that we would have portability to practise throughout Canada, which most of us would have seen as a bonus. That was removed a few years ago, and now we have no portability left in this country.

In addition, the new measures that are going to be introduced will reduce our mobility within Ontario itself, and we'll find ourselves required to stay in certain area. For some, that will be an impossibility due to spousal factors, child factors, all kinds of different reasons. As a result, we might find that they will leave the country completely. That's something we'd like to avoid and that's why the suggestions we have made provide options that will not lead to these kinds of results.

Mr Bartolucci: And they're excellent suggestions.

Ms Lankin: I was interested when you were referring to some of the programs that have been initiated in the last little while, and in particular I'm thinking of the northern residency programs. As I recall from my time as Minister of Health, that was an area we felt had great promise for encouraging northerners to enter the practice of medicine and to stay in the north and practise and to also encourage others to come and do their residency here and then perhaps stay on.

Can you tell me any knowledge you have of the likely results of that? Some of those students are just coming out the other end of it and we haven't really had time to see full-blown, but it would be helpful to get your impressions of it.

Dr Bonin: Actually I just got the newly updated results from our program director today. It's our fifth year in existence. We've had three graduating classes, for a total of approximately 35 or 36 physicians. There are 12 physicians graduating every year from the program: 77% of all graduates of the program are presently in northeastern Ontario or small-town Ontario or Canada; 14% are in urban centres; 6% are pursuing further studies; and 3% are out of work or lost to follow-up. Those numbers surpass any expectations we had prior to getting going.

For a young program our reputation across the country is growing. It's a well-sought program, not only for northerners but for all people wanting to go into small towns. We get one-on-one teaching, hands-on experience, which is not the case in the major centres.

Ms Lankin: The government has indicated that it is going to continue some negotiations, and if a satisfactory result could be arrived at, they may never use the powers in this bill. It's sort of an extraordinary approach, to pass

the powers and have them there. But you said very specifically that you need some certainty, that students who are graduating are having to make choices now about where they're going to practise. I've got letters upon letters upon letters from doctors to Conservative MPPs and ministers, and many of them refer to decisions that they are making about leaving the province. Do you have a sense of what your colleagues are deciding?

The Chair: Your time is up. The government, please.

Mrs Johns: I'd like to thank you for your presentation. I'd like, first of all, to say that I know the program you're in is an excellent program and was set up by a previous government and is doing excellent work. We are trying to do some things with the new government to get medical schools to put people into a northern training program at the early stages, so we have tried to do some different things.

1200

The fee differential you talked about, I was really interested in. I know it's not a new idea, and in fact, rural sections of OMA have been trying to promote this for a number of years. One of the things we've said is that OMA should come to us with suggestions about how we can not implement this billing, that we can do something else. Do you know if the professional bodies will accept this, if the OMA is considering using this as an approach to us? Can you comment on that?

Dr Bonin: Yes. Basically, we're here as a group of northern residents. We do belong to other groups of people that have presented or will be presenting to you. We felt that what they were presenting was not truly what we as northern residents wanted to say, and that's why our presentation varies a bit on the themes that they present. The fee differential is not formally being considered by any of those groups, but we feel that's the only way to get this.

In Canada the rich help the poor. Let's do the same thing as a province and let's get the bigger centres helping out the rural centres. I was told that 1% of billings in Toronto is about \$35 million a year. That's a lot of money. I don't know if it's 1%, 1.5%, 5%; I don't know what the number is. We can get people working on those numbers. But that's the only way to get around this. I know the OMA is considering the creation of a fund from the existing fee-for-service fund that would put money aside for programs such as the ones we were describing. We're the first group, as far as I know, that is formally presenting this option as a realistic option.

The Chair: Thank you, doctors. We appreciate your involvement in our process.

ROCKVIEW SENIORS CO-OPERATIVE

The Chair: Our last group of the morning is representing the Rockview Seniors Co-op homes, Stan Racicot, the president. Good morning, folks. Obviously there's more than Mr Racicot here, so if the rest of you would identify yourselves, we would appreciate that. You have a half-hour of our time. Questions will begin with the NDP, so the floor is yours, sir.

Mr Stan Racicot: Thank you very much, Mr Chair, and good day, ladies and gentlemen. I see you're all

members of the Ontario government. Am I right? Okay.

I have your big book. We had problems getting it but we finally got one. We're short a few pages, though. There are only 234 in ours, so I hope we don't have to go into that too much today.

Now, to start, my name is Stan Racicot, president of Rockview Seniors Co-op, and on my left is my good wife, Peggy, who is our corporate secretary, and on my right is Ron Freeland, who is our office manager. I might say, on Ron's behalf, if it wasn't for him, we would not be there now. The place wasn't just given to us to start up, run the way we like and so on. With Ron as our guide, we built this place. With his guidance, we survived all the problems that come with such a building.

I believe it's the only all-seniors co-op in northern Ontario; that is, I haven't heard of any others. I believe there's room for lots more with the growing population of senior citizens, and yet we hear where 14 co-ops—I heard on TV one night—I clip a lot of newspapers and I have the proof in front of me, but at that time, and it's not so long ago, maybe a couple of weeks ago, I heard the words "closing down 14 co-ops in Ontario;" where, they didn't specify. However, this is scary and we've been scared all along over things that happened here and there, the threats of closure and the threats of giving things over to the landlords to run for profit, and that is scary.

But a little more about ourselves. Who are we? Rockview Seniors' Co-op Homes is a 40-unit seniors' non-profit housing cooperative located at 211 Caswell Drive in Sudbury. The corporation was formed in 1985 by members of Inco Pensioners who became aware of the housing crisis for seniors in the Sudbury region. This group incorporated and pushed for a housing allocation and was successful in securing and constructing a seniors' housing co-op in the fall of 1990. We have 35 one-bedroom and five two-bedroom units which house 46 members who actively and democratically participate in the operations of our co-op. It should further be noted that we have over 400 persons on our waiting list for affordable housing.

We have a board of directors comprised of seven live-in members which meets monthly and general members' meetings are held a minimum of four times a year. We operate under the six cooperative principles:

- (1) Open and voluntary membership.
- (2) Democratic control: one member, one vote; no special favours to some that you would not give to others; free flow of information to encourage feedback; our membership is the supreme authority.
- (3) Limited interest on shares.
- (4) Return of surplus to members.
- (5) Co-operative education.
- (6) Co-operation among co-operatives.

With these principles in mind, Rockview strives to provide decent, secure, affordable, democratic and independent living for the limited number of elders in our region whom we house. Further, we act on issues that will have a direct impact on our members.

Rockview has actively participated in municipal, provincial and federal issues over the past five years. We have attempted to be open-minded and objective in our approach to all issues. It is difficult to work with people and always come to a consensus. However, we attempt to do so.

The current-day government, until now, has shut the door on our efforts to get information and have told us on numerous occasions that they do not have to talk to us. They were given their mandate by being elected with a majority with the Common Sense Revolution in tow. Let us note that we have also requested copies of this document, but have not yet received it.

We are affiliated with United Senior Citizens of Ontario, Steelworkers Organization of Active Retirees, Co-operative Housing Federation of Canada, Co-operative Housing Association of Ontario and many more.

We appreciate the time given to us today to voice our concerns. However, we hope that it does not fall on deaf ears and that this committee is sincere in its limited sessions to consult with the people of this province. We wonder how you will digest the information, report back to your superiors and pass this legislation before the end of the month. We will be watching to see if this was a creditable process or simple lip service to somehow appease the people of this province.

We have participated and voiced our concerns in discussions with the long-term health care committee, substitute decision-making, drug benefits for Ontarians and much, much more. It appears now that the provincial government does not want our help, the wealth of knowledge of the elders, but would rather tell us how we should live and that we must do more with less. Don't forget, we have been through rough times and we know what it is to do without, but never have we had it legislated like this.

1210

Now I want to speak on a petition that we drew up to be sent to Premier Mike Harris and it's on the go now. We've mailed it out to so many people and passed it around to so many groups, mostly seniors but other interested people too. We haven't sent it in yet, but as soon as we get them all back in, we'll be shipping them on. I should say this is from two seniors' organizations headed up by myself, in the beginning, as the president of the two organizations; that is, Rockview Seniors Co-op and the Steelworker Retirees. It goes like this:

"Mr Premier:

"Over the past several years, our two groups have been united in efforts to protect, preserve and improve the way of life for seniors and their families. The board and members of both groups have formed an alliance for continued mutual support now and in the future.

"We, the undersigned seniors, families, supporting groups and people of Ontario are now petitioning you and all members of the Ontario government to stop the Common Sense Revolution which deprives the elderly and favours the greedy, non-caring rich. We list some of our problems:

"—Health care comes first and hospital closures plus cuts in services affect seniors very seriously.

"—Affordable housing: Co-op and non-profit housing

should be increased and subsidized to provide for the growing number of seniors instead of cutbacks which please greedy landlords.

“—Pensions”—I know we’re here to talk health, but this is a petition that you can expect; we’re letting you know ahead of time—“should be properly indexed to the true cost of living, with no cutbacks.

“—Welfare payments should be adjusted to the needs of many unfortunate seniors; cuts are not the answer to this problem.

“—Unemployment”—you wonder why seniors are worried about that?—“ranks high among seniors disgusted at the unnecessary layoffs of their sons, daughters and grandchildren....”

There are a few other things here, but I’ll skip them.

To date, we have thousands of signatures to support this petition and believe that all these issues deserve attention.

Now some more general concerns with Bill 26:

This document compares to an encyclopaedia and deals with so many issues, it is difficult to understand the content and meaning of each. As I said before, it was hard to get. We didn’t how many pages there would be, how many items in it. But it’s scary. It tells nobody, certainly not seniors, “We’re going to do this for you, we’re going to do that for you,” other than cut, cut, cut. We question the reason for such speed in passing this document too. It’s beyond us.

Our concerns with the content of Bill 26, specifically health care: Our first concern with the bill is that it is difficult to understand. We have tried to read the document with the limited time we have and make sense of it. We have drawn our conclusions on what we believe we have read.

Our objections: We object to the way that this public consultation has been conducted and wonder how it could have possibly been set up this way. The lead time for participants is limited and access to information is non-existent. We believe that the document itself should have been circulated with ample time to review and understand its content. Further, we would have liked to have had time to present the document to our members for their input, but the lead time does not allow for proper consultation. Less than a week’s notice is not acceptable and does not allow for the democratic process that our co-op has and needs to operate.

To date, we have received nothing in writing to confirm our participation, the agenda, information or specifics of this public hearing. We fully support public consultation but with due notice and opportunity to be fully informed before the event itself.

We understand that this session deals with health care, which is very near and dear to our hearts, so let’s deal with some of the issues, as follows.

The Advocacy Act: We have a concern that this legislation will probe into our personal lives beyond our will or wants. There is a right to privacy of information; we want that right protected. We do not see how eliminating the Advocacy Act will allow us to make our own decisions with the help of family—advocates—and advisers. We want the right to make decisions for ourselves that will allow us the dignity to live as indepen-

dent, responsible citizens. It now seems that the work and discussion with our membership will have been wasted if these proposed changes are made.

Health care unknowns: The unknown in this document has caused stress and hardship among our members, who are so confused they don’t know what health care they will or will not have. Some will forgo much-needed health care or prescriptions simply because they cannot afford the user fees or dispensing charges. It states that the charge for prescription drugs, other than dispensing fees, will no longer be regulated. Our members have written several letters on user fees and dispensing charges and that it will allow those who can afford the extra cost to get the medication they need and those who cannot afford will go without. We have made our case time and time again without response. When it comes to choices, poorer seniors will choose food and clothing over prescriptions. Is this what you want?

Removal of benefits: The document states that the minister can make changes to remove services from the OHIP schedule of benefits. Once again, this will only ensure that those who can afford the service will get it.

Control of hospitals: It appears that the minister will have the authority to control all aspects of hospital operations. This person will have the power to tell physicians where they can work. How will this be done and what gives this one person the right, knowledge or experience to make such decisions?

The rest of the health care issues are grey at best and we need to know exactly what you mean. Could someone take a few minutes, days or weeks to tell us what you mean? We do not want to buy a pig in a poke.

We cannot support any government that feels it is above the people of this province. We need to live in harmony, with an understanding of the needs for all and a plan of how to accomplish this. You cannot feel that you are superior to the people, and for this reason we ask your committee to relay that we want responsible government, not dictatorship. This can only be accomplished with good leadership, caring and understanding. Are you up for the challenge?

Finally, we would like to also talk about other issues that concern us, such as non-profit housing, pensions, welfare and jobs. However, we’ll have to wait and see if we can get on the agenda of the next meeting, a week from today, I believe? Right.

That’s it. Thank you very much, sir.

Ms Martel: Mr Racicot, I appreciate your presentation and your concern about the complexity of this bill, but there’s one bit of business in this bill that’s not terribly complex and I wonder if you can respond to it. During the election campaign, in fact even before that, in the Common Sense Revolution, the Premier and then Tory candidates during the election made it absolutely clear that there would be no cuts to seniors and the disabled, and secondly, there would be no new user fees.

Mr Racicot, in this particular legislation you will know that there are changes to the drug benefit plan particularly that affect seniors. If you’re a single senior and you make over \$16,000, you’ll pay the first \$100 of your drugs yourself, and after that \$100 you will now pay the dispensing fee and a \$2 copayment on every prescription.

If you're a couple, like the case of you and Peggy, and you make over \$24,000, again the same thing: The first \$100 you pay for yourself, then the dispensing fee and the copayment.

I want to ask you a simple question, Mr Racicot. You and the other seniors, who may have voted for a Mr Harris based on those promises: Do you feel betrayed now? I'm not suggesting you voted for him.

1220

Mr Racicot: It's such a long question, I'd have to tell you a long story and think back about the different people. You see, seniors are over the hill, physically and—

Ms Martel: Talk into your mike.

Mr Racicot: Oh, I'm sorry. It's always been my problem. Speaking at union meetings and other places, I forget to talk into the mike.

As I said, it is a tough question to answer all in one mouthful, because problems are different with different people. But do I get the main point of your question, though?

Ms Martel: Well, there was a promise made by this Conservative government to have no new user fees, and for you folks, who would not have paid any fee for drugs because you would have been on the Ontario drug benefit plan, now certain categories of seniors are going to pay a whole lot more and every senior is at least going to pay a copayment. Do you feel betrayed by that promise?

Mr Racicot: Well, we've had that happen. People are now either buying or doing without.

Mrs Peggy Racicot: Could I answer that question? I certainly do feel betrayed. I have never in my life seen, in all the years that I've lived in this province, or anywhere in Canada, such a dictatorship as what we have right now. I think Mr Harris better come down off his horse there and realize that he can be thrown out just as fast as he got in, before he destroys this whole province, because that's exactly what he's doing. The seniors have fought all their lives to get the best for everyone, and I think he's destroying it not only for our seniors but for our children and everything else. He's destroying this whole province and it's time he woke up.

Mrs Ecker: Thank you very much, Mr Racicot and Peggy and Ron, for coming today and taking time to give us your concerns. I very much appreciate the suggestions and the comments and the points that you're making.

I guess one of the concerns that we have is that the future of Ontario for all of us and our children is in serious jeopardy because we've forgotten one of the lessons that I think our parents and our grandparents were very familiar with, and that was the lesson of knowing how to live within your means. Unfortunately, because we've forgotten that, as many governments in the past, we are now having to pay the price for that, and it is very difficult and very painful but also unfortunately very necessary in very many ways.

I guess one of the things I wanted to clarify, you talk about the Advocacy Act and you say in your presentation that you have a concern that "this legislation will probe into our personal lives beyond our will or wants." I wasn't sure if you were referring to the Advocacy Act or Bill 26 when you made that point.

Mrs Racicot: The Advocacy Act.

Mrs Ecker: It's on page 7.

Mrs Racicot: You answer that.

Mr Ron Freeland: It is the opinion of the co-op that they do go hand in hand and that in fact it's both documents. One gives the opportunity for a probe into a person's health condition, and we believe that that's under the bill, but we also believe that there is an attempt to repeal the Advocacy Act and that that in itself does not protect the interest of the seniors.

But I think one thing you want to be clear of is that, as administrator for the co-op, we have 46 members, our youngest being 60, and you have totally confused—totally confused. When we got a copy of this document of 234 pages, people now are coming into the office saying, "Do I have benefits or don't I have benefits, and what is this government doing?" and quite frankly, we can't tell them.

You have not taken the opportunity to consult us. We have written you on numerous, numerous occasions since your appointment, we have been on your bulletin board, we have been on the Internet trying to make contact with Mr Harris. We wish you'd update those as well.

But we're saying to you, "Confusion, you gave it to us," and confusion we have, and the fear of God is there. These seniors are going to go without, because they simply do not know what it is that you're doing.

Also, we believe—and this is in consultation with the other association that we belong to—that the Advocacy Act, as we understand it, will be repealed in part and parcel and that you will give the opportunity for people to probe into medical records that indeed could affect the lives of people in our co-op adversely, that because of medical reasons they could be put away or be put somewhere else. We have that happening in our co-op right now where families try to put away their parents for greed and things like that. It takes a long time to understand that. Five years in the business, I still have a concern.

So the fear of God is there. Please take that back. These seniors need to be informed what the heck it is that you're doing, because we don't know.

Mr Bartolucci: Thanks, Stan, Peggy, Ron, for an excellent presentation. A few very, very simple questions, but I think they're important.

The government does not consider a copayment to be a user fee. As a senior, Stan, do you consider a copayment to be a user fee?

Mrs Racicot: Yes.

Mr Racicot: Well, I don't know, it's pretty hard when you put it that way. Should I or shouldn't I? I'll come back at you with that. Anything is a user fee. I hear now there's a \$2 user fee on every drug, every single purpose. If there are two different kinds, you pay \$4; three kinds, \$6. Am I counting right?

Mr Bartolucci: You are, Stan. A second question, Ron, and it goes back to what you were saying. Clearly, you are one of a few, you are privileged. You are one of only three seniors' groups that is going to be heard. Do you think that this government must extend these hearings to allow for more seniors' groups to be heard?

Mr Freeland: Absolutely. I do not understand how

this government thinks the way that it thinks when you're dealing—and especially I want to focus on seniors because those are the people that we represent. You need to give these people some time to understand what you're dealing with. You all will get there, and you all, as parents and responsible grandparents and with grandchildren beneath you, will need to understand what the government is doing. This province of ours was forged by these people. You've got to give them some time, and one month is simply not enough.

I read in the paper yesterday where this hearing has given more time than any other. But you know something? You're dealing with more issues than any other.

Let's face reality. Give us some time. Let us understand. We invite you, Janet Ecker, to come to our co-op, talk to us and tell us exactly what this bill means. I say to you, for the seniors—and we have a lot of them in the front row and there in the back—they're here today because they want to understand. But you're not going to stand up and tell us what this means. You're only here to listen to what our concerns are.

Our concerns are that we do not know what it is that you're doing. We want to keep the doctors. We want to keep the hospitals open. We want to be financially responsible. But we want to work together to do it. Give us time to work with you.

The Chair: Thank you, folks. We appreciate your presentation this morning and your involvement in our process. Have a good day.

Mr Racicot: Ladies and gentlemen, I forgot to mention that we do have some of our members here with us today. They're at the back. But they're always with us.

The Chair: Thank you very much, Mr Racicot.

Before we deal with this motion, a couple of things. Lunch will be served in this room, some sandwiches and soup, I understand. Our next presenter's at 1 o'clock, which is a half an hour from now.

Ms Lankin has submitted a motion. Out of respect for time, can we have all-party agreement that we limit the debate to one presenter for five minutes, as we did yesterday? Everybody agree with that?

Ms Lankin: Again with the understanding that I'll split my time between opening and closing.

The Chair: All right. Ms Lankin, we'll let you begin.

Ms Lankin: For those who are listening and to remind people, the motion we're debating is for this committee to recommend to the government House leader that he consider extending the hearings and coming back to Sudbury to hear the people who have applied to be heard here today and won't have that opportunity. There are just over 50 groups or individuals who wanted to be heard here in Sudbury today and there are 13 hearing spaces. So a whole lot of people have been shut out of this process.

The government speaks often about the number of hours of hearings that were offered prior to Christmas. Let me say that in fact they did offer substantial hearings, from 9 in the morning till 10 at night in the week leading up to December 14.

As you heard from the group that just presented—it could be no more eloquently put—this is a complex bill. People didn't even have access to copies of the bill at

that point in time. There wasn't an opportunity for people to prepare, let alone consult with their organizations.

As a result of the efforts of the opposition parties working together, we were able to insist on the hearings being put over to January and to insist on travel so that we were outside of Toronto. Both of those things were very important to us. We had to trade off the number of hours. The government House leader said, "Fine, if that's the way it's going to be, there are going to be fewer hours."

At that point in time, in those negotiations, compromises had to be made on all sides. That's what happened, and a deal was struck. Mr Clement often speaks to this issue and says, "We're going to stick by the deal."

At that time, we had no idea the kind of public response there would be. These two weeks that the committees are travelling, there are over a thousand people have applied to be heard for 274 hearing spots. That couldn't have been predicted, that wasn't known; that is a changed circumstance. It is the responsibility of this committee to report back and to advise the government.

1230

I urge the government members to listen to the presentation you just heard and the concern with the process and the people who want to be heard and who need the time to consult with their memberships to come forward; to support this motion that would bring us back to Sudbury so we can hear from the other people who have applied already and the others who would like to be heard on this bill.

It is important. We've heard you say you're now going to make amendments. You wouldn't have known about some of these areas if you hadn't heard from people. The more we have an opportunity to explore some of the big policy areas which have long-term ramifications for this province, the better-informed we'll be and the better legislation we will pass. I urge the government members to please support my motion.

Mr Clement: I find myself unable to support the motion. I would like to amend it. I think we have 14 spaces today, by my count. That's a minor change, but we might as well be accurate about it.

From my perspective, if you combine all the spaces available both in Toronto and elsewhere for the two sides of this committee, there are 750 slots, by my calculation—I admit it's a personal calculation—for members of the public to have their say, either as individuals or organizations or groups or unions or corporate interests, whatever.

Even in the hearings outside of Toronto I'm pleased to see the diversity and the multiplicity of the groups represented and of their viewpoints. There have been some wide-ranging differences of views we have heard, and all that has been very helpful to me as an individual member of this committee so I can wrap my head around what sort of amendments are appropriate and which ones I would not be prepared to support. That process must continue. We've got nine cities left to go, and I'm quite looking forward to hearing from those other centres and persons who live around those areas.

From my perspective, I disagree with Ms Lankin's

premise. I think the process is working quite well. I can only speak for the government side, but it gives all of us on the government side an ample opportunity to hear points of view—points of view in favour of our position, points of view that are very much dead set against our position. That's precisely what this committee is all about. Hopefully, we can get some amendments that make sense out of this process, and I'm looking forward to the nine other cities' input on that.

At the end of the day, as Ms Lankin knows, government is there to govern and to decide, after having the requisite amount of input. The House leaders, in their wisdom, decided that this was the process we are to follow. I'm committed to this process. By the end of the day, when we come back on January 29, certainly members of this committee and other MPPs who have participated in a number of cities will come back with a wide knowledge of what Ontarians think about this bill and how it can be best improved.

Mr Bartolucci: I speak in support of the motion. It is inconceivable that a committee could be travelling around the province, listening as we have for three and a half days now, personally, to people who all have one thing in common when they address the committee: They say it is too vast and you are not allowing for input the way we should be allowing for input to take place.

If we allow more time, you are going to get more opinions, more amendments that will make this bill better. There is no question that we should be returning here. My constituency office has been flooded with requests from people who, because of many factors, weren't able to get the opportunity to even apply. They want to be heard, and they know the only way they can be heard is through paper. Let me tell you, that is not a fair way to be heard. The fairest way for a presentation to be made is to sit down and discuss face to face so a dialogue can take place. You cannot dialogue with paper; you can only read it.

If we look at the provincial scene, we have had now approximately 1,200 submissions for presentations, 800 of which will not be heard. That should tell us without a doubt that the people of Ontario want extensions to these hearings. We have to ask ourselves the question, what does the government side fear from extending the hearings? What do we fear as a committee, or what do you fear as the government side of the committee, about returning to Sudbury and listening to those groups that are being shut out, that are being refused the opportunity for their submissions to be heard?

We had reference this morning to Dr Bonin and his suggestion. It is an excellent suggestion. It should be receiving public input. The public should hear what he has to say, not only the minister. As I heard Mr Clement's response to Dr Bonin's idea about decreasing the costs for health care, he has not been made aware of what Dr Bonin's presentation is all about. The minister has, and has responded to it in the House. I would clearly say it is imperative that groups like Dr Bonin's group be allowed the opportunity to present.

If common sense can be interpreted as listening to the people of Ontario, clearly common sense is not the rational approach you're using with regard to these

hearings. There is absolutely no problem, and Stan, Ron and Peggy said it: Ultimately and finally, at the end of the day, you're going to pass this bill. Why, then, can you not ensure that the amendments you're going to bring forward are those amendments that will best make Bill 26 a workable one for all the people of Ontario?

It wasn't the case initially. You have now heard some presentations. There is a need for more presentations to be listened to. You are not hearing all of what Ontario is saying. You can only do that by extending the hearings. You are not listening to what all of northern Ontario is saying. You can only do that by extending the hearings and returning to the city of Sudbury to hear future submissions, very important submissions. I would request that the government side change its approach to allowing input. There is no reason you should be voting against this motion by Ms Lankin.

Ms Lankin: Mr Clement, not to split hairs, but there were 13 spaces available today because of an inadvertent booking error on the part of the clerk's office. A group was double-booked and we as a committee decided to add a half-hour at lunchtime. The motion, when it was developed this morning and printed, was correct. We found out that information later upon arriving here this morning.

I want to say to you—and I have said this publicly many times—that the government absolutely has both the right and the mandate to govern and to pass legislation, and I do not in any way believe it is my role as a member of the opposition to try to stop you from passing legislation. I try and change your mind about legislation; I try and ensure that there is a process by which the public has input and that the public might be able to change your mind about all or parts of legislation. In the end, I believe in your right as the government to pass legislation after, as you said—and you used the words; I was amazed—"a requisite amount of input," and I would add "due process."

That is not what we have seen with this bill. Without getting into the history of it, what I want to say to you is that people are coming forward and bringing suggestions in what even you are acknowledging are important areas where you might have to look at amendments. Listen to the other things people are saying: that they haven't had a chance to do the full analysis, to finish their analysis, that they haven't had a chance to consult with their memberships or their clients or their organizations. This process is moving too far, at a speed at which people are unable to have informed input, and a whole lot of people are not able to have any input at all.

I want to remind you what this motion says. It says that this committee "recommends" a course of action to the House leader. The government House leader, with his cabinet colleagues, will still make a decision. He will still discuss that with other party House leaders. You're still in control of the agenda. It's simply a recommendation from this committee.

It is an acknowledgement of what you have been hearing from people, an acknowledgement that people want to participate and that the process that had been set out by the government House leader and the other House leaders isn't sufficient to meet the needs of the public

demand. That's all this motion is. I encourage you to recognize the people of Sudbury who wanted to be heard who are not getting a chance to be heard, in a simple way to recognize that by making a recommendation to the House leader that he consider an extension of the hearings to come back to Sudbury.

The Chair: It's time for the vote.

Ms Lankin: A recorded vote, please.

The Chair: A recorded vote's requested by Ms Lankin. All those in favour of Ms Lankin's motion?

Ayes

Lankin, Miclash.

The Chair: Those opposed?

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated. We'll recess for 20 minutes.

The committee recessed from 1241 to 1304.

PROFESSIONAL ASSOCIATION OF INTERNES AND RESIDENTS OF ONTARIO

The Chair: We're about set to reconvene. Our first presenters this afternoon represent the Professional Association of Internes and Residents of Ontario: Dr Scott Woodside, Dr Margaret Kruk, Lois Ross, Steven Barrett and Dr Michael Franklyn. Obviously, I've named one who's not here.

Welcome to our committee. You have a half-hour of our time to use as you see fit. The floor is yours.

Dr Scott Woodside: Good afternoon. My name's Dr Scott Woodside and I'm president of the Professional Association of Internes and Residents, or PAIRO, and a resident training in psychiatry. With me today are Dr Margaret Kruk, a member of the PAIRO executive and a family practice resident in the Thunder Bay training program; and Dr Mike Franklyn, a former member of the PAIRO executive and a family doctor practising in Sudbury. As well, we have Steven Barrett, PAIRO's counsel, and Lois Ross, our executive director.

PAIRO very much appreciates the opportunity to appear before this committee to address our concerns with Bill 26. PAIRO represents approximately 2,400 residents or doctors in training across the province of Ontario.

PAIRO chose to make its presentation here in Sudbury because much of the focus of our activity over the past several months has been, and over the months and years to come will be, on working with communities in the north, with other underserved communities, with the Ministry of Health and with interested stakeholders in helping to identify and develop effective and lasting recruitment and retention measures. We have been emphasizing the importance of retention measures because keeping doctors in the north, solving the real problems facing underserved communities, cannot be done by force. No matter how many doctors might set up practice in underserved communities, doctors will be able to stay in those communities only if the underlying problem of physician burnout is addressed.

We want to begin by focusing our comments on the

provisions of Bill 26. At the outset, we should be very clear that PAIRO has a number of very significant concerns with many aspects of the health-related provisions of Bill 26. Given that many other presenters have already made representations on those issues, our primary focus today will be on the proposed billing number restrictions.

If enacted, these provisions would provide the Minister of Health and cabinet with the unilateral authority, in their sole and unfettered discretion: (1) to force a doctor to practise in a particular geographic area; (2) to prevent physicians from practising unless they agree to perform services specified by the minister; (3) to impose numerical quotas determining how many physicians can practise in a particular geographic area or area of practice; (4) to prevent specialist physicians from practising unless they are affiliated with a facility; and finally, to effectively prevent many new physicians from practising medicine in Ontario at all.

Separate and apart from questions of constitutionality, legality and morality, the plain fact of the matter is that billing number restrictions will not work to solve the real problems of recruiting to and retaining physicians in underserved communities in the north and elsewhere.

This is not just PAIRO's view. The fact is that virtually every study of the distribution problem has concluded that billing number restrictions do not work and has recommended against imposing coercive measures on new doctors. To give just two examples, the government's own PCCCAR, underserved area needs committee, with underserved community representation, concluded in its 1995 report that "providers should continue to be encouraged and supported—rather than compelled—to choose to practise in underserved areas."

As well, Graham Scott, a former Deputy Minister of Health under earlier Conservative governments, was jointly appointed by the Ministry of Health, the Ontario Hospital Association and the Ontario Medical Association to make recommendations concerning physician services in underserved communities. In his 1995 fact-finding report, based on his discussions with stakeholders in northern communities, he recommended that "the Ministry of Health should provide assurance to physicians who undertake to practise in the rural areas that they are not going to be required to stay there by government decree."

Clearly, there is an overwhelming consensus that coercive billing number restrictions proposed in Bill 26 will not work. There is also widespread support for the principle that underserved communities deserve to receive medical care from doctors who wish to live and work in those communities. As many communities have already indicated to PAIRO representatives, they would rather have doctors who choose to practise in their community than ones who are forced. This is because most communities know that securing new doctors isn't the main challenge; it's keeping new physicians. The real task is to put in place for the first time effective retention measures and programs which will keep doctors in underserved communities and reduce physician burnout. PAIRO is committed to working with northern communities to help to develop a program which will both recruit and retain new doctors.

We should add that billing number restrictions would not work for southern Ontario either, because they won't get any doctors, period. There are many communities in both southern and northern Ontario which either currently have a need for new doctors or anticipate such a need in the future, whether because of retirement, physician movement and aging population or a host of other factors. It makes no sense for the government to deprive many Ontarians of access to the skills of newly trained physicians when, for the first time in 20 years, the number of doctors in Ontario is actually decreasing, or when expert bodies such as the Association of Canadian Medical Colleges have predicted a dramatic shortfall of physicians in the next five to six years. It also makes no sense to deprive many Ontarians of new doctors when the face of new doctors is for the first time increasingly comprised of women and visible minorities. And it makes no sense for Ontario taxpayers to spend millions of dollars training new physicians to provide medical care to Americans.

Dr Kruk will now provide the committee with an overview of PAIRO's activities in this area.

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Dr Margaret Kruk: In late 1995, PAIRO representatives visited with seven communities to explore measures for new recruitment and retention programs. These included Timmins, Manitouwadge, where I visited on December 2, Sioux Lookout, Campbellford, Renfrew, Kirkland Lake and Wawa.

At the same time, and to be continued into 1996, PAIRO launched an advertising campaign called Let's Get It Right This Time, committing PAIRO to working with northern communities and the ministry to help get and keep doctors in underserved areas.

Later this month and throughout February, PAIRO representatives will extend the earlier PAIRO visits to dozens of underserved northern communities to discuss an effective and reasonable recruitment and retention program. These visits are being made at the specific request of the communities involved. The PAIRO visitors will include doctors in training who are currently considering practising in underserved areas. PAIRO has made significant efforts to identify these doctors through its unique access to its resident members. The results of the visits, which PAIRO is calling Dialogue '96, will be discussed with representatives of northern communities and submitted to the minister in March 1996, hopefully in time to affect new doctors' decisions on where to practise as early as July 1996. I have with me an advertisement we'll be running in northern newspapers to inform the public up here of our Dialogue '96.

This committee heard earlier today from a group of PAIRO members who are family medicine residents training in the northeastern Ontario family medicine program here in Sudbury. I am training in the other northern training program in Thunder Bay and intending to practise in the north.

We all agree that the issue of underserved communities is primarily a northern Ontario issue that deserves northern Ontario solutions. That is why, in November, PAIRO initiated our first visits. We were so impressed by the enthusiasm of northern communities for our involve-

ment in solving this problem in December that we decided to undertake Dialogue '96 with northern communities, an undertaking which the minister supports. And we are here in Sudbury today because PAIRO's members are committed to developing solutions that will attract and keep both new and established physicians in northern Ontario. Indeed, many of our members, including seven of 11 members of the PAIRO executive, have told us that they want to practise in underserved areas so long as appropriate recruitment and retention measures are put in place. Many of them will be participating in Dialogue '96.

Dr Woodside: At this time, we'd like to outline just two of the possible measure PAIRO intends to discuss with northern communities during Dialogue '96.

The first of those measures is the direct contract or alternate payment program. Since it was first conceived in 1993, PAIRO has been committed to the direct contract program, which is a non-fee-for-service alternate payment plan for underserved communities. This commitment is evidenced by PAIRO's agreement, back in 1993, to participate and assist in direct contract recruitment activities and to participate in a committee that was to guide and oversee the direct contract program. Indeed, both PAIRO's membership and underserved communities themselves have identified the absence of a non-fee-for-service payment option as one of the most significant barriers to recruiting and retaining physicians in northern communities.

Unfortunately, while the direct contract program was supposed to come into effect in early 1994, the former NDP government never implemented it and the present government still has not implemented it; this, despite the recognition by the Graham Scott fact finder report that direct contracts are "the most advanced alternate payment plan with the potential for immediate use," and would "address the challenge of attracting and retaining physicians."

What would a direct contract program look like?

All of the communities we have already consulted, and others which have expressed their views, agree that the key to the structure of the direct contract program is the recognition that the present fee-for-service system may not be appropriate in smaller underserved communities for a variety of reasons. For instance, it does not recognize the all-day, everyday commitment required of a doctor in a rural or underserved area. In addition, the fee schedule is oriented towards office-based work and so does not address the broader range and mix of services provided by rural physicians.

In contrast, a direct contract program would encourage physician recruitment and retention in underserved areas for the following reasons:

First, in return for agreeing to provide medical care to the community, the doctor would receive stable, reasonable, annual compensation.

Second, in order to prevent physician burnout and isolation, a doctor would be entitled to take reasonable time off, while being guaranteed locum physician replacement services.

Third, a direct contract program would ensure that municipal or hospital clinic facilities and other resources

would be made available to the physician as part of the direct contract. This is of paramount importance for the newly trained doctor.

Fourth, professional isolation would be reduced, through increased accessibility to continuing medical education opportunities and also through formalized academic health science centre support.

Fifth, reasonable on-call coverage would be required, but the direct contract would protect the physician from being required to provide such coverage at an unreasonable frequency.

Sixth, spousal and family support measures would be implemented, which have been recognized to be crucial for physician retention in underserved areas.

Finally, established physicians in northern communities would have the opportunity to convert from fee-for-service to direct contracts, which would help reduce some of the competitive tensions inherent in the present fee-for-service system.

Dr Kruk: A second critical PAIRO suggestion is the expansion of northern and rural training programs. At the present time, there are only two family medicine training programs in northern underserved areas. One is based here in Sudbury and the other in Thunder Bay, where I'm training. These training programs have an excellent record of training doctors who decide to practise in the north, with retention rates of over 65% of graduates working in underserved communities upon the completion of their training. As well, these residency training positions are highly sought after by residents, with up to 200 applying for the 12 positions each year.

However, as the Scott fact-finding report concluded: "Family practice training of residents, other than those at the new Family Medicine North facilities in Sudbury and Thunder Bay, does not fully prepare...(family doctors) for the differences between the well-supported general practice in urban areas and the wider skills burden on" family doctors "in rural areas. This creates an immediate barrier for many young physicians who feel unprepared when exposed to the northern challenge."

PAIRO's membership agrees wholeheartedly. We are committed to actively working with the Ministry of Health, academic health science centres and other stakeholders to bridge this gap between expectation and reality. If rural training opportunities for both family practice and specialty residents are expanded, we can build on the successful track record of the existing northern training programs. Northern communities are entitled to be served by doctors who want to live and work there. Experience has demonstrated that the best way to develop those doctors is by ensuring that they are exposed to training and living in the north as an integral part of their residency programs.

Shifting resources to train doctors in northern communities in areas such as family practice, obstetrics, emergency medicine, anaesthesia, general surgery and psychiatry would also help to provide service support to established doctors already practising in those communities. This would ease their workload, reduce professional isolation, forge links with academic health centres and provide those doctors with reasonable time with their families.

The Minister of Health, in his October 11, 1995, letter to the chair of the Council of Ontario Faculties of Medicine, or COFM, specifically noted that various reports have all concluded that the location and content of training is one of the most important factors in influencing a physician's location of practice. Yet now the minister, through Bill 26, proposes to undermine the real promise and success of those measures in the name of short-term political expediency.

Time doesn't permit us to detail the remaining measures in our brief, save that they include locum system improvement, the creation of a central needs registry, voluntary return of service with restructured financial incentives, expansion of re-entry positions and a responsive specialist backup system.

Dr Woodside: As well, PAIRO is looking forward to the northern communities telling us, during Dialogue '96, which measures they feel are necessary for recruiting and retaining physicians.

The truth of the matter is that, as Mr Clement recognized yesterday, positive, ongoing, comprehensive recruitment and retention measures have never seriously been implemented in Ontario. However, the fact that no prior Ontario government has yet had the will or the capacity to put in place viable, effective and sustained measures to meet the needs of the underserved communities should not now be used by the present government as an excuse to impose negative, coercive and ineffective billing number restrictions. This is particularly the case when, for the first time, the medical profession itself, through the OMA, has stated that it would be prepared to pay for effective recruitment and retention measures out of the fee-for-service pool.

At present, the minister has publicly committed himself to holding off on implementing billing number restrictions in order to give non-coercive measures a chance to work. However, we must admit to being somewhat sceptical about the minister's real motives and intent. The minister is still insisting on including the power to impose billing number restrictions in Bill 26, despite his professed commitment. Then, during the first day of hearings by this committee, he threatened to implement the Bill 26 billing number restrictions unless the 1996 graduating class fills all the underserved area positions identified by the government. The minister himself must recognize that this is not a reasonable expectation.

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PAIRO respectfully requests that instead of threatening new doctors with billing number restrictions, the minister and the government consider the following:

First, one graduating class cannot be saddled with the responsibility of solving decades of inaction by both the government and the profession. Constructive and effective measures must be developed and given time to work.

Second, if Bill 26 is enacted to give the minister the legislative authority to impose billing number restrictions at any time, this will have a chilling effect on the ability and willingness of new doctors to practise in northern communities and will create a climate of uncertainty and instability.

Insisting that the spectre of billing number restrictions continues to hang over our heads will have a precisely

opposite effect to the minister's professed objective of giving positive and supportive recruitment and retention measures a real chance to succeed. Keeping the proposed sections 29.1 through 29.7 in Bill 26 undermines the credibility of the minister's commitment to non-coercive solutions which will really work.

If you knew that, after setting up practice in an underserved community, legislation could be proclaimed at any time preventing you from ever moving elsewhere, what would you do? Indeed, it may well be that if Bill 26 continues to contain the power to impose billing number restrictions, even established physicians in northern communities may seek to set up practice in the south to avoid being affected by future billing number restrictions.

Third, equally important to ensuring effective and successful recruitment and retention of doctors in the north is for the minister to stop claiming that he has put in place the most comprehensive incentive package ever to attract doctors to underserved areas, when he has not. Let us be very clear that all MPPs and northern communities understand one critical fact: The minister has yet to put in place any of the measures which northern communities, expert bodies and other stakeholders have all recognized as critical components in recruiting and retaining doctors in underserved communities.

These include a direct contract program or similar alternative payment plan. The only measure the minister has implemented, the \$70 per hour fee for small hospital emergency service, was never conceived by Graham Scott who recommended it, or by anyone else, as a measure for recruiting and retaining new doctors in the north.

I'd now like to ask Dr Franklyn, who is a member of the first graduating class from the Sudbury program in 1993, to speak to the issue of defining what constitutes an underserved area.

Dr Michael Franklyn: I would like to address a simple point and that is, who determines and how is it determined whether an area is underserved? I am a family physician in Sudbury and was one of the first six graduates of the Sudbury program two years ago. Five out of six of us are still in this community. In the summer of 1993, one of my colleagues and I opened a family practice in Sudbury and were closed within six weeks; I had accepted 2,000 patients in six weeks and closed my practice because I wanted to limit it based on my areas of interest in terms of obstetrics and women's health.

We collected names until Christmas and I still have 600 names sitting on a waiting list, collecting dust, that are very likely never to be served by me. These kinds of services are provided by the newest and brightest doctors who are graduating today.

I'd like to take you back to my struggle in 1993 to open a practice in Sudbury. I was a PAIRO executive member at that time and was told flatly by representatives of the Ministry of Health that Sudbury was not underserved and that were I set up here, I would get 25 cents on the dollar as per the legislation of the day. I found this hard to believe, since I had been working in communities in and around Sudbury and had been asked by some 500 families to accept them into my new practice. The Ministry of Health numbers seemed dramatically higher than those I had counted myself and I undertook a

detailed survey to compare the realistic numbers to the ministry numbers.

The ministry at the time counted 138 full-time practising physicians in Sudbury, when in fact the survey revealed there were 79, for a discrepancy of 58. Those 58 were made up of a number of physicians who had been dead for years, as well as full-time retired physicians and a number of specialists including psychiatrists, oncologists, radiologists, all of whom were counted as full-time practising physicians. Perhaps most astounding was the fact that my name was on the very list and was counted in the head count that prevented me from practising here, along with all six of the residents currently in training who were not in private practice.

Where are we two and a half years later? We're sitting here in Sudbury in January 1996 and I would say the situation is much worse. There's been a citizen's coalition working for two years now to get the city of Sudbury declared underserved. As we sit here today, it is not.

This was the front page of the Sudbury Star. It covered an 80-year-old physician who was watering his daisies. He had billed OHIP \$500 in the previous year, giving his friends flu shots to go to Florida, and he was counted as a full-time doctor.

The number of doctors who have come to Sudbury since I have includes these names. The first five are graduates of the Sudbury program. Two came from out of country and two of these are now on maternity leave. This is the list who have left Sudbury. We're down 13 doctors from where we were in a desperate situation some two and a half years ago, and I only see it getting worse and this legislation can only worsen it further.

Conservatively, if you count 1,500 patients per doctor and 13 have left, that represents almost 20,000 patients who have lost a primary care doctor in Sudbury alone. Some of them may have managed to find a new doctor, but I'm sure that areas in northern Ontario are even worse off. As a family physician, I consider myself first and foremost to be a patient advocate and have nothing to gain by being here today, and I'm here simply to draw your attention to the inability of the government to determine just what an underserved area consists of. The situation is desperate in Sudbury and other areas are worse off.

I certainly am very interested in any workable solution that would find some sustainable mechanism to correct the maldistribution, but as someone looking for a colleague, I certainly don't want somebody who was forced up here against their will. I suggest we should look for sustainable and workable solutions.

Two final points: I would like to say that it occurs to me that the proposed legislation flies in the face of logic and, to coin a phrase, common sense. We're talking predominantly about a northern Ontario problem. To now propose that we'll concentrate and centralize sweeping new legislative powers in the hands of a few politicians and southern bureaucrats in Toronto seems like taking one step forward and three steps backward.

My second and final point is that the new graduates who have spoken to you before this presentation are generally the brightest, keenest and most highly trained physicians ever made available to the public to provide

excellent patient care. They have generally had a minimum of eight to 15 years of post-graduate education, which taxpayers have footed the bill for. They have struggled financially and worked incredibly long hours with awesome responsibilities throughout their medical training.

I'd urge all the members of the committee as well as those of the public to take a minute, take a big breath, and think about these people as being your children or grandchildren and ask yourself, what would they do in that situation? After working so long and so hard, having put their lives on hold for years, if presented with the option of being assigned perhaps indefinitely to a northern or rural community not of their choosing or fleeing to the US, I submit to you that even those who have never considered leaving Canada as an option will pack up their skills, their stethoscopes and flee in droves rather than be conscripted into service in northern Ontario.

Finally, I'd like to say, let's listen to those who with their youth and ambition, motivation and ideas, have the best solutions to this long-standing problem.

Dr Woodside: Two and one half years ago, at a time when the NDP government threatened to impose similar restrictions on new doctors, the Conservative Health critic, now the Minister of Health, stood in the House and drove home to the NDP the "frustration and anger felt by new doctors when they are told that their home province doesn't want them."

We ask the members of this committee and the government to accept the views of the former Conservative Health critic and therefore, first, to endorse PAIRO's approach to getting and keeping doctors in northern Ontario; second, to support PAIRO's upcoming initiatives, including Dialogue '96, and our ongoing involvement in the placement process; third, to recognize that communities prefer doctors who choose to come and stay over doctors who are forced to come and will likely leave; fourth, to recognize that a non-coercive effective recruitment and retention program will get new doctors to the north who will want to stay, whereas billing-number restrictions will not get and keep the doctors the north deserves; fifth, to advise the minister that leaving billing-number restrictions in Bill 26 would create significant uncertainty and instability, leading many new graduates who would have practised in underserved communities to stay away, and potentially driving away some of those doctors who are currently committed to practising in the north; and finally, as a result, to recommend that the proposed billing-number restrictions contained in Bill 26 be removed.

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The minister may have already done irreparable harm to the efforts to recruit and retain physicians in northern communities by including billing-number restrictions in Bill 26. The only way to begin to undo the damage is, first, to immediately remove billing-number restrictions from Bill 26, and, second, to introduce a comprehensive recruitment and retention program comprised of many of the measures identified by northern communities themselves and those that we have listed today.

PAIRO's membership would much rather use its energy, commitment and resources to work with northern

communities and other underserved areas to develop effective and lasting solutions, instead of being forced to use those same resources to combat coercive and counter-productive billing-number restrictions.

Thank you very much for your time.

The Chair: Thank you for the presentation. You've used up the time allotted to you with your presentation, so there's no time for questions. But we do appreciate your input and your interest in our process.

Mrs McLeod: Can we just join in thanking PAIRO for the presentation. It's so compelling that I know it will lead to immediate amendment.

SUDBURY GENERAL HOSPITAL

The Chair: Our next presenters are from the Sudbury General Hospital Association. Good afternoon and welcome to our committee. Unfortunately, I don't have your names, so I'll ask you to introduce yourselves. Any time you leave for questions at the end will start with the government. The floor is yours, gentlemen.

Mr Carl Roy: Just to correct the record, my name is Carl Roy and I'm the associate executive director. I think it's the "associate" in the title that resulted in the typo around "Association." I'm the associate executive director, as I've said, of the Sudbury General Hospital.

Like everyone else who has spoken today to the committee, I thank you for the opportunity to present, especially given that space is at such a premium. With me today is Michael Park, chief executive officer of Network North. Since November 1992, our two organizations have had a formal partnership agreement which has allowed us to organize mental health services into one system in the Sudbury region. This was a voluntary agreement that was motivated by a desire at all levels of our organizations to improve mental health services by reducing duplication and reinvesting our scarce resources in order to fill gaps in the continuum of services that were available to our clients. We are also both members of the Ministry of Health-led hospital restructuring implementation working group that is currently implementing our local restructuring study.

Some of you will be aware of the long and painful hospital restructuring process we've been through as a community. At the initiative of the previous NDP government, since June 1992 we have reviewed our present programs and services and, as a community, determined our future needs. This vision for the future is contained in our hospital services review report. On August 8, 1995, the Minister of Health accepted this report as the blueprint for hospital restructuring in Sudbury.

In the early days of the review process there was an appearance of coordination and co-operation among all the players. However, as our review process dragged on and on and on, what goodwill had existed dissipated, particularly as it became clear that the outcome of the study would be to move from four to two hospital sites and major relocations of clinical programs. This prompted immediate defensive survival campaigns on the part of the hospitals that viewed this outcome as a loss. Rather than celebrating improvements to patient care which were the focus of the report, our community was encouraged

to mourn the supposed loss of programs and buildings. This was accomplished through intentionally orchestrated campaigns that have built on fear-mongering and misinformation.

Thus, at the conclusion of a process that had provided a blueprint for the future, we were still left as a community with arbitrary and uncoordinated cuts to service that often resulted in transferring the costs of care from one facility to another rather than producing efficiencies. As the only facility that receives patients 24 hours a day, every day of the year, in this region we often bore the brunt of these cuts and the inconvenience and risk that they created for patients and their families. Much-needed and long-anticipated capital projects such as a redeveloped emergency trauma facility, which has been on the books since 1987, and the first MRI in northeastern Ontario have simmered on a back burner while we awaited the final restructuring report and the minister's approval. Programs and services at individual sites have been reduced and, at times, completely closed in order to meet financial obligations such as those imposed under the social contract legislation and flat-lined hospital budgets.

Even once our review was approved by the minister himself and clear direction was received repeatedly to implement the service and siting recommendations in the report, local hospitals are still dragging themselves kicking and screaming through a tumultuous and divisive process that has yet to bring about one single improvement to patient care.

As well, here in Sudbury we have a DHC that is very resentful of the commitments made by all three political parties to respect denominational governance in the restructured health care system. You heard this morning that they continue to make direct attacks on Catholic hospitals in particular. We do not believe that the commitments made by the party leaders were designed to give special status to denominational facilities during the local planning for restructuring. We do believe, however, that all parties were committed to the concept that, where a denominationally sponsored hospital was identified to continue as a provider in the restructured system, they should be allowed to retain the structures that ensure their continuance as a denominational facility.

Based on our experience, we recommend that once the advice of the local district health council has been forwarded to the Minister of Health, as per their advisory role as it relates to hospital restructuring, this role should end and they should not be allowed to interfere in the implementation of local studies. To that end, we're supportive of the minister's continued statements outlining the value of DHCs in terms of planning.

Having lived through our hospital services review and our attempts to implement the recommendations, I can fully support the Minister of Health's plea that we not play politics with the health of the people of Ontario. We understand that this bill, particularly as it pertains to health care, is designed to provide the necessary tools to facilitate restructuring. We hope, as always, that voluntary cooperation can form the core of this process. However, we hold out little hope of a voluntary process being successful where there is ongoing resistance to the

approved restructuring plan and implementation process.

Currently, the Public Hospitals Act has limited provisions to encourage cooperative support for restructuring initiatives if individual hospital corporations are opposed and, consequently, sustains the type of resistance we have witnessed in Sudbury. Therefore, we understand the need for the legislative, regulatory and policy changes that will provide the necessary tools to facilitate an orderly restructuring and to clarify the roles of the players, including hospitals and government, in this process.

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Let me emphasize that, based on our experience of hospital restructuring here in Sudbury, we both support and welcome the creation of a restructuring commission. We base our support for the commission on our experience of having been through a review of services which now needs implementing. It is our profound hope that no other community has to undergo the division and bitterness that has occurred here in Sudbury.

We agree with the Ontario Hospital Association's position that the commission must be able to accelerate the implementation of restructuring plans once they have been completed and approved by the minister. We suggest, however, that the commission should only have limited flexibility when it comes to varying the plans proposed by the DHCs once these plans have been accepted by the Minister of Health. We believe that the regulations will need to be quite specific about the issues or situations that may warrant a change in approved plans. While some fine-tuning of program realignment may be necessary during implementation—and this is indeed provided for within the Sudbury hospital services review report—we would caution against too broad a statement allowing for flexibility that could result in further delays or calls to redo studies rather than just fine-tune their recommendations.

We can give numerous examples of repeated initiatives to alter the approved outcome of the study and the resulting delays. Not unexpectedly, this type of resistance comes from those hospitals that do not support the outcome of the local study. With 11 hospitals slated for closure in Toronto alone, the slightest indication that the commission will consider revisiting already-approved studies will compromise successful restructuring across this province. Resistive behaviour should not be reinforced once studies have been completed. Neither should the commission become another forum for lobby efforts or the last court of appeal.

As communities like ours proceed through this often difficult process, it is important that an overall vision for the future provision of hospital services is presented, to reassure our patients, to encourage our employees and to keep all of us on the same track.

We support the Ontario Hospital Association's position that the commission's role be time-limited, and four years seems reasonable. We're pleased to have received notification that the minister has also supported this change. We think that this will allow for communities to complete their planning and implement the results within the foreseeable future. Here in Sudbury, we have first-hand knowledge of the effects an overly drawn-out process can have on patient care, staff and physician

morale and achieving financial targets. We welcome the opportunity for the commission to refine its mandate based on the experience here in Sudbury, where our report is approved and our very bumpy implementation process has already identified the pitfalls and the minefields of translating vision to reality.

When we began our process, we were optimistic that we were planning for a hospital centre that would serve northeastern Ontario into the future. As a community, we have worked hard for many years to develop primary and tertiary care programs and the necessary infrastructure to support these services. We had been able to recruit and retain specialists, usually with promises of the great things to come. Throughout it all we received excellent support from our local MPPs and especially our regional government, which lobbied when necessary, promoted the region and set aside hundreds of thousands of dollars towards the local share of capital funding requirements. All of our local hospitals and the cancer treatment centre, which is now five years old, have run successful fundraising campaigns that time and time again have tapped the generosity of our citizens. Always there was the promise of better things to come.

We now know the reality is that we need to implement restructuring to plan for reductions and hopefully minimize the destructive impact this may have for Sudbury. But at the Sudbury General we also believe we are lucky that our review is done and that we have a vision on which to base our plans for the future. If we move ahead quickly to implement the restructuring recommendations, we may still be able to enhance our services.

By implementing the vision as contained in our hospital restructuring report, we will also have the opportunity to plan for system-wide labour adjustment strategies in order to ensure fair and equitable treatment of those who will be affected by the process. The hospital budget reductions announced in November are lower in the first year and higher in subsequent years. We believe this provides us with a window of opportunity to achieve these financial targets through restructuring the system as a whole rather than making deep cuts at each institution. Taking approximately \$25 million in reductions over the next three years out of our hospital system on top of the money already lost through the social contract legislation results in a total decrease in funding of over \$30 million in this region. This magnitude of reduction cannot be met without restructuring the entire hospital system, and this includes the closure of hospitals as recommended in our approved restructuring study.

The delays to restructuring the system that result from resistance to implementing review recommendations are not only important because of the fiscal context but, as I've already mentioned, in a community such as Sudbury the delay has also meant that much-needed patient care improvements have been held at ransom as individuals and organizations obstruct attempts to move the process forward. This, sadly, has been clearly demonstrated by the unacceptable delays to implementing most of the recommendations from the coroner's inquest into the death of young Jenny Lavoie. Many of the flaws and gaps in the system that were identified as a result of that inquest have also been the basis for the decisions that our

hospital services review committee made in its report to the DHC. As a community, we've known for years that many of our services are fragmented while others are unnecessarily duplicated or triplicated. As a system of health care providers, if we are honest, we know that we can better target care by cutting waste and duplication in the system. We also know that, given the opportunity and the tools, we can be part of the solution.

The tools proposed in Bill 26, as long as they are focused on and time-limited to facilitating the accelerated implementation of restructuring, will ensure that talk about the importance of restructuring is followed by a timely commitment to act on the part of all hospitals. In Sudbury, we believe we are at the appropriate point for the minister to exercise his power through the commission to implement our restructuring plan. He has received advice from the DHC, which supervised the work of the hospital services review committee. The HSR committee spent two and a half years, \$500,000 and thousands of hours in staff and volunteer time to come up with its recommendations. Hospitals had the opportunity to submit their views and to be part of the process. Our community has proposed its solution. Now is the time to act.

We make this recommendation as part of a community that has prided itself on its abilities to develop its own solutions and would not want the commission or any other outside group to intervene. However, it is our opinion that the community stakes are too high in light of the financial challenge and the need for patient care improvement, and the time too short.

If a community accepts the outcome of their review and embraces its implementation, there will in all likelihood be no need for the commission to intervene in the process. However, if, as in Sudbury, you have institutions that do not support the outcome, and in fact do all they can to discredit or overturn the recommendations, then the process can become inextricably bogged down in actions that can best be described as subversive and obstructionist. This is to the detriment of patient care and eliminates opportunities for change and improvement that could otherwise mitigate the impact of the type of massive restructuring that communities such as ours need to undergo.

We note that the OHA has suggested that the minister not delegate the power to close or amalgamate hospitals. In Sudbury, we believe that once the minister accepted the service and siting recommendations and approved that the ministry and the hospitals begin implementing them, he accepted that a hospital would be closed or amalgamated as is outlined in the report. The unknown question is the time frame. The commission should facilitate the smooth transition of programs, human resources and funding in order to achieve the vision that is contained in the report that the minister has already accepted.

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We believe this government is committed to the continuation of voluntary governance of the hospital system. Hopefully, the more extreme measures that appear in the act, such as the appointment of a supervisor or the withholding of funds, will only be invoked when it is truly in the public's best interests, because valid

attempts at a cooperative and collaborative process have failed. Unfortunately, we here in Sudbury know only too well that the public good can be held at ransom by politics. We must refocus our energies on restructuring to provide the best patient care possible within a more efficient system. If this is done, there should be no need for the Ministry of Health to micro-manage the hospital system.

Only if the commission meets continuing resistance should it be necessary for them to appoint a supervisor. However, we can foresee that if a hospital digs in its heels and chooses to resist the implementation of restructuring, it may be in the best interests of patient care and the public good to have a way of ensuring participation in the restructuring process.

At the Sudbury General, there is no question that we believe in the continuance of voluntary governance. We are pleased that the minister has not endorsed or supported regional boards and has rejected the concept of sole governance. This is consistent with the OHA position that voluntary governance be preserved throughout the implementation of restructuring. However, again based on experience, we must say that if existing hospitals are not willing to implement the service and siting recommendations that result from local reviews, we understand perfectly well why mechanisms such as the restructuring commission or the appointment of a supervisor may be required.

Change is always difficult. It's hard for people to accept realignment and closure of programs and facilities. In many communities like ours, families and individuals have devoted years of loyalty to "their" local hospital. Hopefully, the commission will be able to build upon the voluntary contributions of board members and assist in reorganizing their talents to meet the needs of the redesigned system. The same will be true for staff and physicians within the system. In reality, what is needed from the commission is to act as an outside arbitrator to facilitate and accelerate the implementation of approved plans. And above all else, we need a way to ensure that we are able to maintain the public's confidence and get on with providing the best patient care we can for the residents we are here to serve.

We can also understand the need for another of the strategies proposed in the legislation; namely, the power to impose terms and conditions on loans and grants to hospitals. The unfortunate reality is that withholding financial support or transferring funds from one facility to another may be the only meaningful incentive to ensure cooperation in the restructuring process, short of appointing a supervisor.

In section 6(d) of the proposed bill, reference is made to the power of the minister to make any direction related to a hospital that is considered to be in the public interest. We believe that in Sudbury, the public interest as it relates to the provision of hospital services, specifically where, how and by whom these services are provided, has been well served by the 2½-year HSR study. This comprehensive study reviewed how the Sudbury hospital centre could be better managed as a health care system within the available resources.

We are gratified that the minister and the ministry will

now have the tools and, when necessary, the big stick to enable communities such as Sudbury to move beyond the quagmire of endless debate and stalling tactics and on to doing the best that we can for the benefit of our citizens with the resources that are available to us.

Thank you, Mr Chair.

The Chair: Thank you. We appreciate your presentation. You've left this committee with one of its largest challenges, the chance at one quick question each, with the emphasis on quick, starting with the government.

Mr Clement: Thank you for your presentation. It certainly is a cautionary tale which you tell. I only wish I could bottle the presentation and share it with other cities, because it might provide help to them as well. From your perspective, then, the powers that the minister has under this bill are necessary and in fact welcomed in order to break some logjams?

Mr Roy: Most definitely.

Mr Clement: Can you expand on that?

Mr Roy: We have been at the table with a number of Ministry of Health staff since September 18. I just came from a meeting. We met last evening as well. We've been meeting roughly two days a week to implement the plan. We've had extensive discussion groups making recommendations for how we can best implement the recommendations on patient care service improvement.

We still have two hospitals that, when the ministry asks, "Can you agree with this?" say, "I'm sorry, but the position of our hospital is that we will do nothing until sole governance is established." Up until the minister's direct, face-to-face clarification in November of his position—this was the fifth clarification this minister has provided—hospitals were saying the review hasn't been decided.

I think this points to, to be fair, the tremendous stakes in restructuring, and as long as these provisions are based at reshaping and reforming the system, then they're well needed and will ensure that we expedite getting on with improving patient care for this community instead of squabbling about who's going to control the system.

Mrs McLeod: I'll try and be very brief in respect of the time of the committee, because I think the minister is giving himself somewhat unenviable powers to step into local rationalization/restructuring discussions, and I actually think he does have the power now. One of the reasons why ministers of Health tend to step in and then rather tentatively withdraw is because it is so difficult to find what is a consensus among a community and what a community feels is in its best interests. That's become apparent as we've heard presentations in Sudbury today, and I think all of us knew some of the history coming in.

You should know that the district health council made a very strong representation today also in support of ministerial powers provided that the minister's powers were exercised in accepting DHC reports and including changes to Bill 26 that would allow for a sole governance model. Mrs Ecker from the government indicated that the minister intended to utilize his new powers by acting on DHC recommendations. If that were to be the case, I suspect you would have some concern about the minister stepping in and making that kind of decision.

I guess it comes down for me, and I will make it as

direct as I can, that I don't think there's any way around communities having to wrestle with what is in their best interests. I'm wondering whether or not—and you can't answer this in two seconds, I know—there is a better way of getting the stakeholders at the table, of determining what is community and how does a community have its say, so that we don't have to continue to go through the divisiveness. These are going to be tough decisions, and I don't think the Minister of Health can make those decisions in Queen's Park without having come in and really understood the nature of a particular community.

The Chair: Unfortunately, Mrs McLeod, you didn't do nearly as good a job of asking a quick question.

Ms Lankin: There are two areas that I would like to touch on quickly. One, with respect to your recommendation that the restructuring commission be sunsetted, I wanted to point out to you that the Ontario Hospital Association in its presentation said that the minister's stated intent to amend the bill and to put a sunset clause on the commission wasn't sufficient, that in fact the extraordinary powers that the minister takes on to himself with respect to hospital restructuring, mergers, closures, appointments of supervisors, a whole range of things, should be sunsetted. While some of us may debate how necessary those measures are to accomplish the goals, putting that aside, if they're there in the bill they should be sunsetted. So I wanted to ask if you were in support of the powers as opposed to just the commission.

Secondly, very quickly, you make some very strong arguments about the DHC's reports being at the basis of the action of the hospital restructuring commission. I agree with that completely and I'm wondering if you would be supportive of amendments to the bill that at least gave the restructuring commission some terms of reference or mandate and at least some reference to DHC reports, because as it is right now, there is nothing in the bill that builds that linkage in.

1400

Mr Roy: In terms of the first question, yes, we do support the OHA's suggestion that the elements of section 6, I believe, around the appointment of a supervisor also be sunsetted. Sister Winnifred McLoughlin, on behalf of the Sisters of St Joseph of Sault Ste Marie, will be addressing that particular point in her presentation later this afternoon.

Again, we link it to restructuring and see these provisions as tools to get the job done, because we need to get the job done. In terms of reference to DHC-approved plans, yes, I firmly believe that the DHC plans must be the blueprint. To give credit to the DHC, I think it did an admirable job in a process that was designed to significantly reduce the hospital system, inform the public of that reality and give them full opportunity to express their point of view, but I wouldn't give it a perfect report card in the process either. I think there needs to be an acknowledgment of the DHC's work, and that's why I stressed the importance of the commission responding to approved studies, after the minister has received the advice.

The Chair: Thank you very much, gentlemen, for your presentation. We appreciate your interest in our process. Have a good afternoon.

CENTRE DE SANTÉ COMMUNAUTAIRE DE SUDBURY

The Chair: The next group is the Centre de santé communautaire de Sudbury. I understand the presentation will be made in English, but if anybody wants a copy of the French version, it can be made available to you. Welcome to our committee. You have a half-hour of our time, and questions will start with the Liberals, should you leave any time. The floor is yours.

Ms Juliette Denis: I would ask the committee to go to page 6. I would like to start by explaining a bit what the Centre de santé communautaire de Sudbury is all about. We're a non-profit community health centre that provides a wide range of culturally sensitive health and social services in French to the francophone population of the regional municipality of Sudbury. Special attention is provided to the youth, women and the elderly. Particular emphasis is placed on prevention, health promotion and education relating to the determinants of health.

Our mission is to assist our community to improve its level of wellbeing and, ultimately, to attain an optimum level in this respect. We believe that in order for this to happen, each individual member of our community must take responsibility for his or her own health. This is why the centre invites and greatly values public participation in all matters relating to the wellbeing of our community members.

Centre de santé communautaire de Sudbury recognizes the need and the urgency for reforms to Ontario's health care system. We support such reforms provided that the following principles are not placed in jeopardy: democracy and the rights and responsibilities of all Ontarians; the Canada Health Act, such as comprehensiveness, universality, accessibility, portability and public administration; quality of care; and fairness and equity for all Ontarians.

We are concerned about the potential negative impact that some provisions of Bill 26 can have on these principles. We believe it is possible to bring about reforms that will on the one hand provide for a more efficient and affordable health care system and on the other hand protect these principles and improve the wellbeing of Ontarians. This belief forms the basis for our presentation today and for the recommendations we are submitting.

I'll just explain a little how the report is prepared. We have identified areas of concern, and you will find under most of them the area of the proposed bill that's involved, the one we are particularly worried about. I'm not going to go through that while I'm reading, but it's there for your reference at a later time.

The first area of concern for us is the use of legislation to effect change. We appreciate the need, as well as the urgency, for reforms, as we've said before. However, we are concerned about the potential for an overutilization of legislation to bring about change, for the following reasons. Every time a law is passed, it restricts, to some extent, our rights and freedom. Once a law is passed, it is often very difficult to modify, as Bill 26 serves to prove. It is even more difficult to have it repealed.

Our society seems to have reached a point where practically every change has to be effected through

legislation. There are often other alternatives available through already established mechanisms or organizations to allow for the same changes to be effected. For example, we believe that with clear guidelines, hospital restructuring could undoubtedly be done effectively through the district health councils, in collaboration with the Ministry of Health. This would prevent having to resort to additional legislation to attain the same result.

As a recommendation for this point, we would recommend that where feasible and appropriate, district health councils, in collaboration with the Ministry of Health, be made responsible and accountable for the health services restructuring.

Recommendation 2: that if Bill 26 is deemed to be essential, it be reviewed to determine if it properly addresses the true causes contributing to the need for health reform, and if not, that it be amended accordingly.

The second area of concern is the unqualified sweeping powers and their implications, and the reasons for our concern are as follows:

These provisions provide the potential for the powers to be used beyond their original intent at a later date. It could be by a subsequent government, for example. They provide the potential for the erosion of our democratic system. With all due respect, such unqualified sweeping powers, if legislated, are comparable to the acquisition of a duly signed blank cheque. Existing legislation already provides the Minister of Health with a wide range of authorities and powers which might be adequate to bring about the necessary reforms.

Third, legislative process could be subordinate to the regulation process, and the reason this creates a concern for us is that the regulation-making process is not subject to public debate in the Legislature or in a legislative committee. Regulations should be used only to detail broad powers that are already contained in the statute. Since Bill 26 does not clearly define the broad powers for the proposed Health Services Restructuring Commission, the regulation process could be used to assign new powers to the government.

In order to prevent that, we'd like to offer recommendation 3: that if additional legislative powers are necessary to bring about the required health reform, they be clearly delineated in the legislation.

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Another area of concern is the lack of government liability and accountability towards its electorate. This creates a problem because the provisions dealing with that severely limit the public's ability to question government action and to hold the government accountable, except through the political process. The general absence of opportunities for public consultation or appeal creates undue risks.

The recommendation on that point is that Bill 26 be amended to add provisions for appeal mechanisms.

The fifth area of concern is the potential for duplication, and the reasons for our concern there are that the establishment of the Health Services Restructuring Commission provides the potential for duplication in regard to district health councils, and the assignment of a hospital supervisor who has "the exclusive right to exercise all the powers of the board" provides the

potential for duplication in regard to hospitals' boards of directors. This provides the potential for undue additional costs, which goes counter to the very purpose of Bill 26 itself, dealing with fiscal savings, streamlining and efficiency.

We are further concerned about the implications for district health councils for the following reasons: The establishment of a health services restructuring commission could render our health care system more complex and confusing by adding yet another level of bureaucracy. This does not seem to support the purpose of streamlining and efficiency. Further, it creates the potential for undermining the role of district health councils.

We are also concerned about the implications for the duly incorporated local boards of directors, for the following reasons: Bill 26 does not make provisions for public input and consultation. The assignment of a hospital supervisor provides the potential for the erosion or nullification of the authority and autonomy of duly incorporated local boards of directors. This further provides the potential for total lack of local autonomy, authority and accountability of decision-making.

Concerning the last three points, we would like to offer this recommendation: that Bill 26 be amended to eliminate the potential for duplication, the undermining of district health councils, and the erosion or nullification of duly incorporated local boards.

Another area of concern is the extensive use of the term "in the public interest" and lack of public consultation, both taken together. The reason for that is that the term "in the public interest" is not defined; there are no specific criteria for determining what constitutes "public interest."

Bill 26 does not make provisions for public input or consultation. This is not consistent with the Progressive Conservative Party's pre-election position, as stipulated in the document *Bringing Common Sense to Health Care* dated December 1994, and I quote: "The public should be a key player in determining local community health care priorities." This is also inconsistent with the Progressive Conservative Party's commitment in the document *Health Care Bill of Rights*, which stipulates the "right to participate in decision-making."

Lack of consultation limits the government's access to valuable input that may identify innovative and viable alternatives that may further improve the system. It also provides the potential for making decisions based on false assumptions.

It provides the potential for unfair and inequitable treatment among the various areas of the province due to lack of knowledge, understanding or consideration of their specific needs and health status as influenced by gender, age, disability, socioeconomic status, geography, culture, ethnicity and language.

It provides the potential for greater resistance to change due to a lack of opportunity to input during the planning process.

We have two recommendations on this point, the first one being that Bill 26 be amended to add the following:

—A definition of the term "public interest";

—Criteria for determining what constitutes public interest, including reference to the diversity of Ontario's

population as it relates to the varying levels of health status as influenced by gender, age, disability, socio-economic status, geography, culture, ethnicity and language.

Recommendation 7: that Bill 26 be amended to add provisions for public consultation before major decisions are made.

Our ninth area of concern is the potential for unfair and inequitable treatment.

The first area concerns the establishment of the Health Services Restructuring Commission for the following reasons:

—Bill 26 does not clearly define criteria with respect to the composition, the mandate, the duties and the duration of the mandate of the proposed commission.

—This provides the potential also for unfair and inequitable treatment among the various regions of the province due to lack of knowledge, understanding or consideration of the particular needs and differences.

—Subsection 8(8) provides the potential for unfair and inequitable assignment of duties to members of the commission itself, thereby undermining the role of the remaining members.

—The potential thus created is also inconsistent with that of a democratic system.

We would like to offer the following recommendation: that, if the establishment of a Health Services Restructuring Commission is deemed to be essential, Bill 26 be amended to add the following provisions:

—A clear definition of its mandate, duties, powers and accountability;

—A clear definition of its composition, one that ensures fair and equitable representation for each region;

—A clear delineation of the duration of its existence to ensure its dissolution once it has accomplished its mandate;

—The same mandate, duties and powers for all members.

The second area of concern in that respect, where you're talking about establishing independent health facilities, is for the following reasons:

—Bill 26 does not make provision for public consultation, thereby creating the potential for major changes to be implemented in this respect without public input.

—The removal of the provision giving preference to non-profits and Canadians provides the potential for serious prejudice against non-profit organizations and Canadians.

—The proposed clause 5(1)(a), relating to requests for proposals, creates the potential for both unfair and inequitable treatment and for conflicts of interest when proposals are invited.

—These provisions are inconsistent with that of a democratic system.

We would like to offer the following two recommendations in that respect.

Recommendation 9: that the present provisions, 6(3) and 6(4) of the Independent Health Facilities Act, be retained.

Recommendation 10: that Bill 26 be amended to delete clause 5(1)(a) of the Independent Health Facilities Act.

The third area with respect to inequity etc is that it

limits choice for some patients or clients. The reasons for our concern are:

—Extensive powers are, once again, given to the regulation process, thereby curtailing public discussion and debate.

—There is no clear definition of the terms "family status," "family unit," "expenses incurred" and the class of patient referred to in section 23, thereby creating the potential for discriminatory practices.

—These provisions have the potential to be discriminatory by limiting the choice of certain classes of individuals.

—They also have the potential to ignore or under-emphasize important health issues which may also affect drug choice.

The tenth area of concern is unprecedented disclosure of personal information. We are seriously concerned with these provisions for the following reasons:

—Confidentiality is a most crucial fundamental right.

—These provisions pose a real threat by providing the potential for serious infringement of clients' rights.

—These provisions go against the principles of democracy.

—Quality of care has the potential to be diminished since some clients might withhold some information for fear of its being divulged to some third parties.

—The mechanism used to collect personal information directly or indirectly, and the purpose of collecting such information, are not defined.

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—There is no provision to require client consent or to ensure that the information cannot lead to client identification, especially when such information is disclosed.

—There is no apparent appeal mechanism in situations where confidentiality has apparently been breached.

—This contradicts the Progressive Conservative Party's commitment expressed in the health care bill of rights, "...right to participate in decision-making regarding one's own health and the right to treatment free of discrimination and which recognizes one's privacy, dignity and individuality."

Recommendation 11: that Bill 26 be amended to provide for the protection of patient-client confidentiality.

Another area of concern for us is the lack of provision for consultation or input of significant partners or key players. As already mentioned, the government can greatly benefit from public input and consultation. This applies equally to significant partners and key players such as the Ontario Pharmacists' Association, the Ontario Medical Association, hospital boards of directors, employees etc.

The next point we'd like to address is physician management distribution. We appreciate the intent of these provisions and we can identify with them, as our centre has been experiencing great difficulties in recruiting physicians for over a year now.

Although we have no concerns about the provisions themselves, we are concerned that they target the symptoms of the problem and not the true causes underlying the problem, as identified by physicians themselves. These include, among others, lack of replacement to allow for time off and lack of access to colleagues to

allow for consultation. We believe that, in order to solve the problem on a long-term basis, we must address these causes and find appropriate solutions such as, for example, maybe a travelling team of physicians ready, willing and able to provide replacements from town to town, the use of technology, such as medical imaging, to allow for consultation etc.

We'd like to conclude with the following comments. Within the time constraints, Centre de santé communautaire de Sudbury has reviewed the provisions of Bill 26 relating to health issues. We recognize that some aspects of Bill 26 might be essential to bring about reforms to our health care system. We also appreciate the fact that the government is anxious to attain the goals that it has been elected to accomplish.

We further appreciate that time is of essence and that this decreases the amount of time normally taken at the various phases of the change process. Nevertheless, we are concerned about the potential negative impacts that some provisions of Bill 26 can have on the principles that we have outlined.

We are particularly concerned about those provisions that grant unqualified sweeping powers to the government, coupled with the absence of provisions for public consultations or appeal.

We are also seriously concerned about the implications of the proposed amendments relating to access and disclosure of personal information.

Finally, we're concerned about the potential for unfair and inequitable treatment in a number of areas.

—We believe that Ontarians have a right to a democratic system;

—That the government must remain accountable to the public and must ensure that there are mechanisms in place that allow for this to happen on a regular basis;

—That Ontarians have a right and a responsibility to provide input into the areas that affect their wellbeing;

—That the government can greatly benefit from public consultation. For example, it can help to identify additional pros and cons and alternatives, some of which might be more easily acceptable, lead to greater improvement and be more efficient and economical;

—That making a change that is deemed to be in the public interest without consultation may lead to an action based solely on a false assumption.

—We also believe that what may be in the public interest in one area of the province may be very different in another, due to geography, socioeconomic factors, cultural and language differences, diversity etc.

We therefore urge the standing committee to seriously consider our recommendations. We do believe that it is possible to bring about reforms that will, on the one hand, provide for a more efficient and affordable health system and on the other hand protect these principles and improve the wellbeing of Ontarians.

Thank you for having provided us with the opportunity to provide input on Bill 26. We take this as a positive sign that the government does in fact value public input.

The Chair: Thank you. You've left the members of this committee with their second consecutive challenge at one quick question each.

Mrs McLeod: Having failed the last time.

Mr Bartolucci: Thank you for your very excellent presentation and recommendations. I kept on thinking about the principles of the Canada Health Act as you were speaking: those of comprehensiveness, universality, accessibility, portability and public administration.

Do you think Bill 26, in its present form, strengthens or erodes the principles of the Canada Health Act?

Ms Denis: In its present form I do believe it has the potential to erode some of those principles.

Mr Bartolucci: Quick enough, Mr Chair?

The Chair: Very good. Thank you, Mr Bartolucci. Congratulations.

M^{me} Martel : Madame Denis, c'est bien évident que vous-même, et je pense d'autres membres de votre organisation, avez étudié très bien le projet de loi. Vous avez aussi donné des recommandations pour améliorer, si c'est possible, ce projet de loi. Alors, merci pour votre travail.

The one question I wanted to ask has to do with the definition of "public interest." The government wants to give itself some very broad and some very exceptional powers and says it will do all of this in the public interest, which has yet to be defined. At the same time, the government also protects itself from any possible court challenge or legal proceedings while it does all of these things "in the public interest." Can you tell me what confidence you have, then, if the government is trying to protect itself from court proceedings, that what it wants to do will be in fact in the public interest?

Ms Denis: I have a hard time comprehending how public interest can be determined without implicating the very public itself.

Mrs Johns: Thank you very much for the presentation. I especially appreciate both the concerns and the recommendations you have. They're very well laid out.

I wanted to say the government is committed to maintaining the Canada Health Act. We haven't taken a stand like Alberta has at this particular point.

Can you just explain to me a little bit about why you believe in limiting choice of some patients with the Ontario Drug Benefit Act? I was just interested in that section. I never read that out of it. It's on the top of your page 15.

Ms Denis: I have the bill with me. I won't be able to quote by heart, but if you want, we can take the brief back. It does mention that the government can limit drug choices and it does stipulate for certain classes of individuals and it doesn't qualify those certain classes, so the door is wide open. It's a worry because, which classes? For what reasons? We can't weigh if they're good or bad, so it's really a reason for concern.

The Chair: Thank you. We appreciate your being here to make your thoughts known to us.

1430

SUDBURY AND DISTRICT MEDICAL SOCIETY

The Chair: The next group is the Sudbury and District Medical Society. Good afternoon, doctor, and welcome. Identify yourself and then the floor is yours.

Dr Chris McKibbin: I'm Chris McKibbin, a doctor practising medicine in Sudbury. I was born and raised in

northern Ontario and have spent most of my life both growing up and working in northern Ontario. Mr Chairman, I thank you for the opportunity of being here.

Honourable ladies, gentlemen, it's a challenge to be here to attempt to respond to the changes that are envisioned for health care in the Savings and Restructuring Act, Bill 26.

I refer to it as a challenge because the amendments proposed that would affect health care touch virtually every aspect of patient care. The way in which hospitals are run and administered, the medications that are available and how those medications are made available, and the shape of the interaction between an individual patient and his or her physician are all influenced by the package of legislation which is under consideration before this committee.

It is something of a paradox that because the act is so comprehensive it may well ultimately be incomprehensible. To work through the implications of any one of schedules F, G, H or I is in itself a mammoth task. As such, the best that I can do this afternoon is to draw your attention to some of the concerns that prompted our request to appear before your committee this afternoon.

Let me say at the outset that we understand and support the need for a financially responsible and fiscally sustainable health care system. We believe we can no longer mortgage the future in order to pay for the wants, wishes and whimsies of the present. Clearly we need to define what health care is, what it's about, how it should be provided and who should provide it. We thank this government for bringing those concerns to the fore.

Within the Sudbury and District Medical Society we've been saying for years that we cannot have infinite health care with finite dollars. There are certainly ways in which we can do more within the funding envelope the minister has promised. There can be no doubt that there is some waste, that there is duplication within the health care system, but it also needs to be recognized that in health care, as in all other aspects of our life together as a society and as a province, government need not do for people what people can appropriately do for themselves.

This desire to be all things for all people at all times, dressed up under the guise of accessibility and universality, is eventually leading us down a path where our health care system will lose the capacity to respond to the acute and real needs of people that cannot be met by individuals and families themselves.

I recall another revolution where the rallying cry was for free bread, and bread in fact was free, except there was no bread. Here in northern Ontario, we're acutely aware that a magnetic resonance imager is to be free, but there is no MRI. We're acutely aware that the services of an endocrinologist are to be insured and available and accessible, but there is no endocrinologist.

I would like to briefly focus on each of the sections that are under consideration and to share some of our concerns, convictions about their potential and very real problems.

Schedule F deals with those amendments necessary to accomplish a significant restructuring of hospital services. In his address to the committee, the minister quite rightly pointed out that almost 7,000 beds have been closed

piecemeal across the province in recent years. Physicians, nurses and the people who work in those hospitals—administrators, dietary staff, housekeepers—have in the face of this downsizing provided an increasing quantity, complexity and quality of care of which we can all be proud.

We've reached the point, however, that we can no longer labour under the infrastructure, the bricks and mortar, the competing institutional agendas and the duplicated and triplicated administrative structures that rob the patients of our community of the front-line, hands-on care that they deserve and expect. Like 30 other communities across the province, we are knee-deep in the muck and the mire of hospital restructuring. It's been a difficult and a painful task at times. At times it seemed as though we were knee-deep in the muck, but knee-deep, down face first.

A Health Services Restructuring Commission, functioning in an arm's-length relationship with the minister's office, working cooperatively with district health councils, hospital boards and medical staff, would be a welcome relief. There needs to be a recognition, however, that communities about the business of restructuring can depend and rely on secure commitments for financial support, and the ability of the commission not only to downsize and remove funds but to distribute and reallocate the funding both between hospitals and across communities, if hospital restructuring is to work.

At present, one of the crucial questions to be answered in our experience is the need for a comprehensive, fair and equitable labour adjustment plan for both union and non-union workers alike. We are concerned that in Bill 26, this concern is conspicuous by its absence.

Of even greater concern are the provisions of schedule F which will allow for the revocation, suspension and non-renewal of physicians' hospital privileges where hospitals close or where their mandates are substantially altered. It seems unconscionable to believe that physicians who have served their patients and their communities, some for many years and often at great personal cost, should suddenly be bereft of any right to appeal changes that will dramatically affect their life and their livelihood.

Amendments are urgently needed that would recognize the physician's de facto contract with a hospital, perhaps as it's determined by the period of time served, and provide, if not through the courts then by an alternative dispute resolution mechanism, a means to address and resolve the very real issues that physicians will experience in this situation.

Amendments are further required, as questions of physician supply and distribution prompt consideration of often draconian solutions, that will protect the eligibility of physicians to find opportunities to continue their practice in the communities where they have long served. Such an alternative dispute resolution mechanism might play a very constructive and creative role, not only in mitigating damage but in matching hospital needs and physician services as restructuring proceeds. It would ensure that valuable skills are not lost to the people of Ontario. Victims have a tendency to protect turf and parochial interest in a situation of uncertainty.

I would like to briefly hand the floor over to my colleague, who I'm quite glad has arrived, Dr Jack Hollingsworth, who is the past president of the Sudbury and District Medical Society.

Dr Jack Hollingsworth: I'm glad to see this committee's running exactly on time, just when I got stuck with a sick patient. It would have to happen.

It's indeed an honour to be allowed to present, albeit briefly, to this committee.

Most responsible citizens, and indeed physicians, respect the need for fiscal restraint in the face of a mounting deficit. It is clear that the government of Ontario cannot continue to spend 10% or 20% more than its revenue, and there's a broad sympathy for this government's commitment to live within its means.

The old adage "Don't tax you, don't tax me, tax the man behind the tree," is often changed by special interest groups to say, "Don't cut you or me but the man behind the tree." But this is not the purpose of my presentation.

The physicians of Sudbury have consistently attempted to work with all governments, and most recently this government, in attempting to find creative solutions to often severe health care problems. The Sudbury and District Medical Society has been very active in promoting and assisting in the restructuring of local hospitals because of our understanding of these fiscal realities I just referred to.

The purpose of my presentation is to bring to your attention some points you may not have considered in this legislation, which was drafted without consultation with the medical societies around the province or indeed the Ontario Medical Association. I will direct my comments to schedule G, which refers to pharmacology and drug issues, and I'll try to illustrate to you some potential unintended effects of Schedule G.

Schedule G is a series of amendments to the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act to be renamed the Drug Interchangeability and Dispensing Fee Act, and the Regulated Health Professions Act. I'm just going to cover some points which I hope I can make reasonably quickly, and if I go too fast, you could perhaps stop me and ask questions if you like, but I'm going to try to cover several points and give several illustrations of what I'm talking about.

The first thing I want to focus on is the small group in society of about 15% of people who do not have any drug coverage from their workplace and have no insurance provided by their employer. These would include workers at fast-food restaurants who may exemplify the working poor. These people do not qualify for ODB and yet have a low income. Other people in the same category would be uninsured small business people, and this would include many self-employed people. Indeed, it would include many doctors.

Unlike doctors who know about alternative and cheaper therapies and can perhaps bargain with pharmacists, many of this 15% of our general population cannot negotiate and don't have the knowledge to select a cheaper drug or know where the lowest dispensing fee is in any particular city.

Under the current changes in schedule G, pharmacy fees will be deregulated and this may result in two things:

either lower fees or higher fees. There's to be no regulation of this as far as I understand. Some of these people will therefore be possibly charged more for dispensing fees, and the groups of people involved in this may be many people laid off under the current realities in the province; in other words, corporate restructuring. This would include the nearly old-aged, the person who is 54 who's been laid off because of corporate restructuring, who's not old enough to be 65 to get an ODB card. You many find that many of these people indeed voted for the Conservative Party in the last election and you may wish to consider this group of people carefully.

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As I go through each point, I'll try to illustrate a potential solution.

Some consideration should be given to expanding ODB coverage on an income-based cost recovery basis. This would work out at about \$200 to \$800 per year and would allow these people to have some drug coverage.

The second point I want to illustrate for you is government control. While a government system may save many people from hardship and suffering, unfortunately it can never be as efficient as the marketplace in keeping up to date with recent breakthroughs. The current amendments would see the government taking a greater role in establishing eligibility and coverage and establishing clinical guidelines. One problem with government setting clinical criteria is that there is a vast literature to be surveyed. There are about 12,000 medical journals out there and about 10,000 new articles per week, so best of luck if you're going to take over the drug regulation industry.

My solution to this would be to allow exemptions, to allow physicians to prescribe some unlisted drugs and some indications you don't already have covered, or to perhaps employ expert physicians in each specialty to umpire requests. You already have a mechanism, special authorization forms, which have been around for several years, but actually it would become a lot more stringent, as far as I can understand.

One example of this government control where you really can't keep up to date is a bug that causes ulcers, called H-Pylori. As of yet, the Ministry of Health seems unaware of this, even though they've been told many times, by me, physicians around the province, Ted Boadway at the OMA, many people, that to treat this bug we need to use certain drugs such as Losec and Prevacid. The only indication the ministry allows is for a severe reflux disease or hiatus hernia problems. So we have to regularly lie on your special authorization forms. It doesn't come easy to us, but we do it.

Another example where you're perhaps going wrong in going to cheaper drugs is only allowing drugs to be given three times a day, for example, the older drugs, whereas once-a-day dosing is quite possible. This is particularly important where you've got a young family with two parents working and Johnny goes to school and no one's there to give him his medication, or you've got an elderly person in a nursing home and the nurse has to make four trips a day instead of one. You don't really save any money.

My solution to that would again be to allow some

exemptions and to listen to the physicians.

Issues of confidentiality have already been covered. I won't dwell on this—you've already been hammered quite hard on this—but there is a specific point I want to make, that some of these amendments under schedule G will allow you access to College of Physicians and Surgeons of Ontario information on physician prescribing and ODB information from the computerized network.

Under the amended version of section 13 of the ODB Act, government will have further discretionary authority to "collect, directly or indirectly, use or disclose personal information for purposes related to the administration of this act or for other purposes prescribed by the regulations." This would mean that the minister could impose penalties or sanctions to physicians who do not prescribe according to your clinical criteria. I've already stated that your clinical criteria may rapidly become outdated.

My solution to this problem is not to gather information you don't need and don't intrude into physicians' offices or practices, and don't fall into the trap of blaming all ills on physicians.

I want to briefly cover two other points, if I can have two or three more minutes.

Drug substitution is another issue that's quite important. I did bring some information for those of you who are interested afterwards. The current amendments make no allowance for instructions by physicians for selected patients to have proprietary, brand-name medications with "no substitution." If I write a scrip for you and put "no substitution," then it cannot be substituted. But the current amendments won't allow for that. The problem with this is that there have been serious drug interactions when patients have been denied their proprietary, brand-name medications. Some of these have involved cardiac and respiratory drugs and some have been quite severe. Under the proposed amendments, patients affected by these interactions would not be entitled to receive coverage for their proprietary, brand-name drug.

My solution for this is to continue to allow no substitution for selected patients.

I have several other issues that are perhaps going to take more time than is allowed. I'm trying to run through this fairly quickly.

Part of the solution to your problem may be to look more closely at drug utilization review, which is the concept of looking at the usage of medications on a community basis. This may be a solution to some of your problems. We know that for every \$1 spent on that, you can save \$20. So there's some role for drug utilization review, preferably at arm's length from the government. If it's driven by only cost containment, it will not be as helpful as if it was driven by improving patient care.

The final point I wanted to make was the effect of formularies on physicians and patients. In many areas, there are four or five formularies. If you're a physician in Kitchener-Waterloo, you've got to deal with Manulife, Mutual, The Co-operators and the ODB. Some of these will change; some will be frozen at particular times. Physicians become confused as to which drugs a particular patient is allowed to get. You should try to encourage some consistency between public and private plans. This has been recommended in the past by the Ontario

Pharmacists' Association and the OMA.

In closing, I would ask that the Common Sense Revolution be applied to health care as much as possible, that you try to get away from central planning and government bureaucracy. We need to allow physicians to prescribe drugs in a cost-effective way, with allegiance to patient care. We mustn't just use cost containment as the only measure of success.

I'd like to thank you very much for your time. I don't think we'll have time for questions. I'll pass the floor off to Dr McKibbin.

Dr McKibbin: Thanks, Jack. Schedules F and G, the formation of the Provincial Health Services Restructuring Commission, deals with the need for an institution to deal with other institutions. The institution of the Ministry of Health quite properly exercises its authority over the management of other institutions and industries under its umbrella. Problems arise, however, when institutions attempt to interpose themselves and interfere with relationships between individuals, and it is precisely this problem that comes to the fore when we consider schedule H of the Savings and Restructuring Act.

In his address to this committee, the minister made the assumptions underlying this section of the legislation clear. "Physicians," he said, "act as the gatekeeper to the health care system. This role brings with it serious responsibilities not just to the individual...but to the strength and viability of the health care system itself."

What is wrong with this? It seems in many ways very sensible. Well, ladies and gentlemen, what is wrong here is that it places the state, the ministry and its bureaucracy, on equal footing, having the same rights, as the patients seeking care. This conscription to dual responsibility and the odious measures contained within this act to enforce compliance, coupled with the complete absence of any alternative to state-run medicine, is objectionable in the extreme.

I want you to know, ladies and gentlemen, and to remember, if you remember nothing else from our presentation here this afternoon, that we are not gatekeepers, bureaucrats or bean counters; we are doctors. When I close the door to my consulting room, when I stand at the bedside of a sick patient, when I sit with the family of a terminally ill person and struggle with them and their family to determine the next and best course of care for that individual, there must be no question of divided loyalty. Whether it is in ordering a test or seeking the opinion of another colleague to clarify a patient's problems, there must be no doubt, in my mind or in the minds of patients, who is being served. Medical decisions must be made, because of the application of a physician's training, experience and commitment, that are unreservedly committed and confidently received to the service of one single goal: the best interests of the patient.

The minister states reassuringly that the necessary authorities of schedule F will be tested against the criteria of the public interest; institutions are necessary to deal with institutions. But as a physician and as a patient, I do not have the luxury of divided loyalty. I must make decisions based not on personal interest, not on public interest but on patient interest.

As legislators, it's your responsibility to encourage,

facilitate and to resist any attempt or authority that compromises this fundamental principle that lies at the heart of the privileged relationship between a patient and his or her physician. It's at the heart's centre of all understandings of the ethical, moral and effective practice of medicine.

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What follows from this is the need for amendments which apply this principle to the proposed legislation. Sections of the act which propose that doctors will be liable for the cost of investigations, referrals or treatments later determined to be medically unnecessary—a term as yet to be defined—must be removed in their entirety. It is impossible to practise medicine in an environment where decisions made in good faith can be second-guessed. These proposals will cripple medical decision-making and further an atmosphere where defensive medicine becomes the prominent concern and which fails to serve patients well.

Amendments are further required which will specify the situation in which a review of practice is required. What is objectionable and requires further attention is the appearance and very real possibility of an unwarranted and arbitrary set of actions driven by debt reduction and book-balancing rather than by the need to ensure quality and responsible patient care.

Amendments are further required which specify the time of practice, the duration of practice, that is subject to review. Will the review look at two years, one year, three months, one month of medical practice? Clearly, a prolonged period of eligibility for review, potentially occurring long after particular services are provided, is by its very nature punitive. A defined period of eligibility, the results of which are removed, in their first instance at least, from financial penalty, offers the opportunity to improve and enhance medical practice rather than to second-guess it and destroy it.

We share the minister's concern that scarce financial resources must be directed to the provision of front-line, hands-on medical care. Amendments are required which limit the growth of the government bureaucracy that is implicit in the provision of powers to appoint inspectors to facilitate schedule H.

We welcome this government's commitment to achieve control of the size of government bureaucracy and its conviction that the people are best served by less government, not by more. We are concerned, however, that the provisions of schedule H envision a veritable army of bureaucrats that will cost the taxpayers of this province dearly and will divert the resources that we agree are needed for patient care in a wasteful witchhunt.

One of the most interesting articles in recent years appeared in the *American Journal of Medicine* early last year. It was an analysis of the rising costs of medical care in the United States, attempting to determine where the money was being spent. It graphically contrasted the rising cost of medical bureaucracy against the commitment of funds for direct patient care. Expenditures on patient care were either flat-lined or falling, but the cost commitments to administration and bureaucratic control rose progressively. We must reverse and not reproduce this American experience.

The question of physician payment is the subject of much of schedule H, and I want to remind the committee that in recent years the physicians of this province have provided somewhere between \$300 million and \$400 million in medical services for which they received no compensation. This was provided in a health care system which the minister referred to in the closing paragraph of his remarks to this committee as the best health care system in the world. Mrs McLeod, Ms Lankin, you also have referred to this province's health care in the same sense. These comments have been echoed by physicians, by patients, by politicians both inside and outside the Legislature. We agree, and we agree unreservedly. The problem is not the quality of care. The problem is that we cannot afford it.

Is there anything right in this legislative proposal? Well, there are the seeds of an honest recognition that we cannot go on as we are, that radical change is necessary. This lies behind the minister's desire for the authority to unilaterally set fees, determine what are to be considered insured services, and raise questions concerning medical necessity. In many ways these are the right questions to ask.

However, the answers ought not to be provided by legislative fiat that gives the ministry bureaucracy an unprecedented power and unbridled authority to shape the direction of health care. What is necessary is a wide-ranging, urgent public discussion aimed at shaping the boundaries of accessibility.

The federal Minister of Health has demonstrated herself incapable of giving leadership in this vital area, continuing only to write cheques with promises that her treasury cannot cash, when what is needed is a radical reconsideration of what the Canada Health Act not only says but what it must mean in the day-to-day provision of health care in our province.

Those of you who are opposition members of this committee have heard your leaders and colleagues call for this legislation to be broken up, to allow for the legislative and public discussion and debate necessary to determine what services will be provided, by whom, where, at what cost and who will pay. Certainly, the dialogue is urgent. The fiscal realities are pressing. We support, with amendment, the need to restructure our hospital sector. There has been a wide-ranging discussion in many communities throughout the province, and that discussion will continue in still other communities. We need to get on with the job.

This, after all, is where we spend the largest share of money in the health care pie, and pharmaceutical costs represent probably the fastest-growing item in the health care budget. Clearly, there needs to be an opportunity for innovative control here. We need to get on with reshaping these vital areas now. But let's not miss the opportunity to involve the people of the province in the dialogue which is necessary to begin the revolution they voted for on June 8.

I would urge you to withdraw schedule H in its entirety, not because it affects me but because the people of Ontario must have an opportunity to engage in an urgent dialogue about the direction of health care in our province as it affects the personal, privileged relationship

between the physician and patient.

Mr Chairman, my apologies that I don't have the typewritten text of my remarks here this afternoon. I'll fax them to you and make them available to your committee in the morning. I'd be pleased to answer, with my colleague, any questions I may have provoked.

The Chair: We have our third consecutive challenge; it's getting tougher all the time. We've got about a minute per party, one quick question.

Ms Lankin: Thank you, Dr McKibbin and Dr Hollingsworth. Your presentation was helpful and there was a very measured and constructive tone to the suggestions that you've made and to the criticisms you've made.

I was particularly struck by your use of the term "conscription to dual responsibility." It really captured for me what you were intending and it helped me understand that very clearly.

The government says both with respect to confidentiality but also with respect to transferring the decision-making about review of medical necessity of treatment that's been provided to the general manager of OHIP as opposed to a review by the Medical Review Committee, that that's to follow up on fraud and inappropriate billings etc.

One, I'm concerned about the nature of powers that are being given to follow up on a problem which I still believe is a very small rate of occurrence in our health care system, physician billing fraud. I think we would all admit it does occur, but I think it's a very small problem. How do you feel, as a doctor, about having somebody in the Ministry of Health who is neither a physician nor a professional peer of yours making decisions retrospectively, I guess, about what has been medically necessary treatment that you have prescribed for your patients?

Dr McKibbin: I think that what you raise is the question of what is medically necessary and who is in the best situation, by training, by talent and by commitment, to make those determinations. I do not believe there presently exists a mechanism in order to do this for the purpose of the recovery of moneys. And you have to be sure and clear that the intention of this act, a savings act, is about the recovery of moneys. So I would appeal that we need some definition to the question of medical necessity. We need to be quite clear. And this is not something that Dr Hollingsworth and I can give you an answer to, nor is it something that you will likely come up with.

Basically, what we can tell you is that as a people, as a community of communities in this province, we need to be about the business of defining and determining what is medically necessary. Otherwise, we're left with what is very arbitrary.

Mrs Ecker: Thank you very much for an excellent presentation. I appreciate your advocacy on behalf of your patients and the system.

A quick question of clarification. I thought, Dr Hollingsworth, you were talking about how you thought drug utilization review was a good thing to do, but I wasn't clear. At the same time, you seemed to be saying that the information sharing, the access to information that is needed to do the clinical guidelines and to measure the outcome of the clinical guidelines and how well it's

working—you were questioning our ability to access that information. I just wanted to clarify; I wasn't sure if I understood that's what you were saying.

Dr Hollingsworth: You've got a good question there. Drug utilization review is useful on a community-wide basis, and that's generally accepted by most people. The problem is when you get down to the individual patient and individual physician and you become quite intrusive in the physician-patient relationship.

But if you look at how much Lescage we're using, how much Zantac we're using, how much of any drug you'd like to name, that's an important question. How much codeine are we using in Ontario? Do we need to use as much? These are important questions to ask. But to ask, should Dr McKibbin be using a certain type of arthritic pill or not is a bit more intrusive and I think less valuable to society. That's the point I was making.

The other point is the health care network, the ODB network. There have been a lot of problems with confidentiality. The information the pharmacist gets, as far as I know, is very limited in its usefulness, for confidentiality reasons.

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Mrs McLeod: As you're undoubtedly aware, in schedule H when it comes to determination of "medically necessary," it sets out a new framework of "prescribed medically necessary...under such conditions and limitations as may be prescribed." The old act would have a definition of "medically necessary" determined. It would be "all services rendered by physicians that are medically necessary," and where there is any dispute about that, it would have been determined by the Medical Review Committee. I think that the old act is consistent with the Canada Health Act, which defines "insured services" to include, among other things, physicians' services, and that means "any medically insured services rendered by medical practitioners."

To make it a direct question, do you believe the dialogue that you've said needs to take place, and I agree, in terms of defining the boundaries of medical accessibility and therefore the boundaries of our publicly available health system can take place still within the framework of a Canada Health Act definition of services to patients being those rendered by physicians? Secondly, do you think that, before we get into a discussion of dialogue that is premised on rationing, there is more work to be done in terms of clinical evidence of effective treatment that can be shared, not for the purpose of recovering funds but for informing good clinical practice?

Dr McKibbin: On the question of the development of ongoing clinical evidence, one of the first rules in the courtroom of medicine is that the evidence is never always in. We can't wait forever for evidence to begin to practise medicine. One of the first things you learn in medicine is that you need to be able to function in a situation of ambiguity, so I would not wait for crystal clarity before we engage in the debate.

The question of medically necessary services being those services which are provided by a physician raises the question of who will provide medical care, and I hope that I'm hearing your question correctly. I think this is an important question. I think that the people of the province

of Ontario and the nation have generally felt well served, both by physicians and by other people within the health care system.

The question of whether we can broaden who is providing insured coverage is again something that we need to talk about, something that we need to dialogue about, because the answer may be very different in Hornepayne than it is in Hamilton. It might be very different in Attawapiskat than it is in Windsor.

The Chair: Okay, doctor, I'm going to have to cut you off on that. I've been a little generous with the time anyway. We do appreciate your time. I'm glad that Dr Jack had an opportunity to join us. We appreciate your interest in our process and being here this afternoon.

Ms Lankin: Mr Chair, I'd like to table a question, if I might, at this time. I had hoped to be able to follow up on this with the representatives of the medical society but because of the shortness of time I couldn't.

This morning, in response to a presentation by the ACCESS AIDS Committee of Sudbury, Ms Johns made a statement informing them that they should not be concerned about the changes in who was going to be judging or determining medical necessity. In the process of providing that response to them, she suggested that the job of the tariff committee of the OMA was to assess and determine medical necessity and that they would in fact continue in that role, so that the people who had raised the concern should not be concerned.

This is very big news to me, that the tariff committee of the OMA is responsible for determination of medical necessity. In fact, I think it was misinformation that was provided. But I would like to table a question directly to ask if that is the ministry's intent in the future or if something has changed in the recent past that would have provided that responsibility to the medical tariff committee of the OMA.

Mrs McLeod: Mr Chairman, I also have a question to table for the Ministry of Health staff, following again on this discussion and assuming that section H is not about to be struck through a government amendment process, although it seemed like a highly desirable suggestion.

I would like to know from the Ministry of Health staff whether or not they believe that under section 1 of schedule H, which prescribes conditions and limitations, there can be any regulations made which would not be in contravention of the present definitions under the Canada Health Act of "medically necessary."

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair: Our next presenter is Vickie Kaminski, the president of the Registered Nurses' Association of Ontario. Welcome to our committee. You have a half-hour of our time. Questions, should you allow time for them, will begin with the government. The floor is yours.

Mrs Vickie Kaminski: Thank you very much. It is indeed a pleasure to be able to address a provincial committee in Sudbury for a change instead of having to travel to Toronto. I don't have a handout for you. The Toronto office decided it would be foolish to courier it to

Sudbury to give to you to have to carry back. It will be available to you in Toronto when you get back, which will cover this. But I'm confident that my presentation will be memorable and captivating and you won't feel deprived of not having notes in front of you.

The Registered Nurses' Association of Ontario, just for background, is a professional nursing association that represents a network of about 13,000 nurses across the province of Ontario who work in a variety of settings throughout the health care system. One of RNAO's main goals is to help empower the people of Ontario to achieve and maintain optimal health and promote healthy public policy in doing that. We're very pleased to be able to be here today, and I will attempt to be brief so there is time for questions should you have any.

We are very concerned that the health components of this bill do not represent true health care reform but are instead a fiscal attempt to introduce restraint and control into a health care system that's already fragmented and will continue that fragmentation unless there is some revision to the bill as it stands.

Our system is definitely in need of reform, and reform in the health system is something that RNAO has gone on record in the past and still believes in, through the past two government and again with this government. We're very happy to be able to work with you in reform in a very much-needed environment.

However, the proposals in Bill 26 are a reflection we believe of what happens when a fiscal agenda attempts to define health care reform. Fiscal constraint is not appropriate as the sole rationale on which to base reforms. I would like first to comment generally on the implications of this type of legislative package and then move to more specific comments on some of the content.

In December 1994 Premier Harris indicated an important government direction in Bringing Common Sense to Health Care. He promised "to empower the consumers of the health care system with the rights to proper care and to participate in decisions regarding that care." This government gave a commitment to public input in the determination of programs and services for each community, and I recognize that this kind of consultation is part of that commitment.

However, we believe that it is not enough and that public input has been noticeably absent in the introduction of this bill. The initial push to pass the bill through without the opportunity for debate and the difficulty experienced by many members of the public to access hearings such as this are but two manifestations of this problem. We are very concerned at this disregard of critical public debate on issues affecting all Ontario citizens. This bill has compromised partnerships and trust built over time between the governments and the public.

Therefore, RNAO strongly recommends that the government consider dividing this act into smaller acts, thereby permitting more discussion. This allows the government to fulfil its promise by allowing more opportunity for public participation in these critical health care issues.

Turning to the specifics of the proposed legislation, there are many components that fundamentally challenge our health care system, and that's good. Some of the

principles, however, of the Canada Health Act will be seriously jeopardized, and that we believe to be a situation of grave concern to everyone.

In our presentation today, I will discuss areas of general concern that pertain mainly to schedules F, G and H, and I will go through them as quickly as I can, with the recognition that there will be some additional comments that I won't be making today that will appear in our written brief. Specifically around some of the health human resource planning issues, we will touch on them but I would invite you, after you've read the brief, if you have questions, to be in touch, since we won't be going into it in detail today. Indeed I was challenged last evening by my colleague Dr McKibbin to come today and have the nerve to say that physicians should go on salary and expect to leave the room alive. I think he will be pleased with what we have to say as we move into that portion.

1510

First of all, we recognize and applaud the government's efforts to introduce more quality assurance measures into health care provision; for example, an investigator assigned to review the quality of a hospital's administration, management and patient care will now potentially have greater ability to determine the presence of organizational impediments to achieving good client care. We believe this carries significant potential to address some of the care problems that may be beyond the power of individual practitioners to resolve.

Many of our members have witnessed difficulties in delivering optimum care because of inadequate or inappropriate staffing, resulting, for example, from restructuring efforts. We are relieved that there will be entrenched recognition of the accountability of organizations for quality care. However, we do have some concerns about the actual changes in ensuring improved care, since there is very little recourse for appeal or consultation prior to that decision-making.

Generally, the increase in ministerial powers is evident in many of the proposed changes. The minister is empowered to reduce, suspend, withhold or terminate services or funding and accept or reject proposals for the establishment of facilities and services with little or no appeal by the public. There is little, if any, definition of these powers, how these powers will be exercised or their extent and duration. This much power cannot afford an ambiguous definition.

Therefore, RNAO recommends that the minister's power be defined and the terms and conditions be clearly articulated to avoid any ambiguity as we move through this process. Furthermore, we urge the introduction of a sunset clause, to ensure that these powers are appropriately limited.

We detect a general tendency in the proposed extended powers to move the government into a more micro-management role in some aspects of clinical decision-making. We believe that the government's energies are better spent in designing, supporting, coordinating and funding a comprehensive health care system.

This is certainly a critical government role in assisting and guiding the public and providers to determine an appropriate health service for each community. However,

we are most concerned that in its efforts to cut costs, avoid duplication and increase efficiency, the government is forgetting some of the important elements of the change process, such as appropriate consultation. Therefore, RNAO recommends that the government continue to consult with the public and health provider groups in its health care reform agenda.

According to current legislation, the minister has the power to determine fraud and to investigate fraud. These powers already have implications for compromising privacy or confidentiality to records. Health and patient records are highly confidential and access should ideally be restricted to the client, the health care provider and, when necessary, a specified or regulated reviewer such as an OHIP investigator. However, Bill 26 contains provisions that will allow the government unprecedented access to personal information.

While RNAO does not dispute the government's right to investigate fraud within the system, we believe these increased powers of access and disclosure are unnecessary, given what we believe to be the advent of fraud. Going back to a question posed earlier by Frances Lankin, does fraud happen that often? Do you need this kind of sweeping power to investigate that sort of situation? We believe you don't.

The opportunities for unnecessary breaches of confidentiality are enhanced when more individuals have access to confidential information and data. Furthermore, the government's freedom to disclose information with any party it chooses is troubling because of the potential loss of control to organizations that may be beyond Canadian governance. We have seen that across Canada in other jurisdictions already.

RNAO recommends that appropriate criteria, therefore, for accessing patient records and health information be clearly delineated and strictly enforced. There must also be consistency with the Freedom of Information and Protection of Privacy Act. We further recommend that whenever the government deals with external agencies or organizations, there exist clear criteria regarding the control and protection of that confidential information, so that we don't see lists of patients' names, for example, being sold to outside agencies or to foreign companies outside Canada.

In several sections of this bill, the government or its delegates are protected from liability. Again, in *Bringing Common Sense to Health Care*, it's emphasized that there is an importance of accountability at all levels of the health care system. RNAO considers the government an integral and vital link in the health care system. It is responsible for setting policy, funding, articulating of vision, and coordinating an integrated and comprehensive system. Just as all health care providers are accountable in this system, so too should the government be accountable for its actions. We have great difficulty in accepting this double standard being proposed by the government.

We recommend, therefore, that as an integral link in the health care system, the government must be held accountable for its actions, and we suggest that the way to do this is through criteria and guidelines for some of the minister's intended actions, that they be made clear to avoid ambiguity and chance for error.

In a related accountability issue, this bill provides for unprecedented ministerial power but lacks a corresponding set of appeal mechanisms by the public. Where appeal mechanisms do exist, there is often a financial charge in order to lodge an appeal. This prohibits, or restricts at least, those unable to pay from being able to appeal. That, we think, is a fundamentally undemocratic process.

Therefore, we would recommend that in the interest of the public good, alternative mechanisms must be instituted to facilitate an appeal process.

On the issue of restructuring, we read with interest what the act was proposing. The Ministry of Health Act allows for the establishment of a province-wide Health Services Restructuring Commission to carry out duties assigned by the minister. While the commission's role is to facilitate and accelerate the implementation of hospital restructuring, it appears only to address the restructuring of the hospital sector. Reform that addresses only one piece of the system will encourage a fragmented rather than a more integrated system in health.

We recommend, then, that the role, mandate and terms of reference of the restructuring commission, again, be clearly articulated to take other sectors into consideration and to avoid public confusion and critical gaps in care being created or exacerbated.

We are concerned about the possibility of service gaps that will compromise the health of Ontario's citizens. The expressed intent to accelerate the process alarms us. While we do believe that hospital reform and restructuring are necessary and we're happy to participate in those discussions, we believe that the changes in hospital services are both the cause and the result of changes in community service and medical practice. Recent trends in health service clearly indicate that community support services must be available, and in sufficient quantity, to support hospital restructuring.

For example, with reduced lengths of stay in hospitals, there is an increased need for home support nursing services for the medically complex patient. The increased use of ambulatory care centres increases the need for accurate assessment both pre-admission and pre-discharge. To restructure hospitals to move in these two directions without having the community supports in place will cause the restructured hospital to be inappropriate in its dealings with patients and will provide less than appropriate care for people as they move through the system.

That's not to say that we should not be restructuring or reforming hospitals. We should, and indeed we must, carry on with the work that's been started in communities like Sudbury and in fact across the province. But we must also do that looking at the community piece and keeping that as important and as front and centre as some of the big-bang hospital restructuring seems to be.

The trends to deinstitutionalize patients in order to care for them in the home and the use of more volunteer labour must be addressed at the same time as province-wide hospital restructuring begins. This dependency on volunteers requires a more flexible, educated and knowledgeable workforce that can quickly assess changing circumstances in a client population. If these service gaps,

again, are not addressed up front, we believe that there will be more suffering experienced and more money eventually spent dealing with complications arising from inadequate care.

We recommend, therefore, that changes in non-hospital sectors such as long-term care must not only be identified but that strategies for implementation must be articulated and resources must be committed to these activities in advance of implementing any system-wide hospital restructuring program, or at least at the same time.

The restructuring commission is set to commence work as soon as the bill is passed. However, restructuring has occurred at different rates in all regions across this province.

Again to quote the document *Bringing Common Sense to Health Care*, the public is identified as "key players in determining local community health care priorities." We agree that there must be an opportunity for each community to discuss and articulate its needs for successful province-wide restructuring to occur. We believe the current district health council structure enables this type of public participation to occur and should not be ignored in this process.

We therefore recommend that the commission strengthen and work with the existing district health councils to allow for planning and decisions about regional health service needs that are sensitive to the community differences that only health councils are in a position to articulate.

1520

The proposed legislation states that commission members from the health sector, business and broader community are to be appointed by the ministry. We would like to urge that you ensure that the health sector representatives have nursing representation on this commission. Nurses are active participants across the entire spectrum of health promotion and care provision. This breadth and depth of experience is critical to any comprehensive health care planning and restructuring.

The proposed legislation contains frequent use of the expression "public interest." The minister is given power to reduce, spend, withhold or terminate funding to a hospital if it's in the public's interest. While we commend the government's intention to determine services and funding in consideration of the public's welfare, the concept is not well defined in the bill. Who determines what's in the public's interest? Whose value system defines those criteria?

"Public interest" is also inconsistently applied throughout the bill's terms. While it is used extensively in the *Public Hospitals Act* to rationalize the minister's powers to intervene, it is conspicuously absent in the *Independent Health Facilities Act*. For example, while RAO recognizes that public interest is a changing reality that depends on specific community values, there must be province-wide consistency in the appropriate consideration of public interest.

We would recommend that "public interest," again, be clearly defined and that there be consistently applied rationale underlying all of the health care reform.

As we move into the issue of privatization, again we would like to make the following presentation.

The amendments to the Independent Health Facilities Act may well challenge our universal, accessible, publicly administered health care system in Ontario by creating an environment that allows for more privatization. Proposed amendments in section 7 repeal the language that directs the minister to give preference for non-profit facilities and protection of priority to Canadian-based proposals, which will encourage, we think, proposals from for-profit, non-Canadian organizations. Although this may signify the government's receptivity to foreign firms entering the Canadian health care market, we are doubtful that the majority of Ontario residents would share this view.

These amendments increase the opportunity for conflict of interest and enhance the potential of a two-tiered health system emerging in our province. Proponents of the two-tiered health system argue that those who are willing and able to pay for service should be allowed this choice. However, there are considerable data indicating that a two-tiered health system is not only more costly in the long run, but also leaves millions of citizens without equal access to service. RNAO believes strongly in preserving the tenets of the Canada Health Act and the Canadian health care system, and accessibility is one of those main foundations.

We would recommend clear direction, guidelines and controls to ensure non-Canadian corporations and organizations, if they are invited to enter Canada and Ontario for the purpose of health care delivery, meet the standards integral to the Canadian health care system; and that mechanisms such as quality assurance controls be an essential aspect of any contract we may enter into as a province with these agents.

With user fees and insured services, again, under the Drug Benefit Act, what's being proposed, we would express to the government, is fundamentally the introduction of user fees and is contrary to election promises made in relation to health care. These fees have severe ramifications for social assistance recipients and seniors receiving guaranteed income supplement, who will now be required to pay an annual deductible fee and all dispensing fees. We are in effect punishing the elderly and disadvantaged for being ill and old or disadvantaged. Furthermore, the human costs of this policy will be tremendous for children and families.

User fees and copayments will not reduce the need for prescription drugs, but they will reduce the number of prescriptions that are filled. We believe that when confronted with these extra charges, many individuals will be forced to choose between food or medication.

We are convinced that instead of saving money, this particular approach will result in greater expenditure. The complications and side-effects suffered by those unable to afford needed medication will be even more expensive to treat.

The issue of drug use needs to be addressed in a way that does not disadvantage the elderly or those on social assistance.

We recommend, therefore, that the government address the issue of a proper drug utilization program as opposed to charging user fees; and that this be the solution to deal with the rising costs of the drug plan.

In this proposed legislation, the government will no

longer pay the difference between what it considers interchangeable products, even if the prescription calls for no substitution. This means that if the individual requires a specific drug no longer paid for by the plan, he or she will have to pay the difference.

While we agree with the principle of interchangeability, in practice this is not always feasible. I'm sure you've heard that articulated earlier in your hearings. A cheaper drug may not be a feasible alternative for all individuals, so we would encourage you to allow for individual need and difference to be considered in the development of drug policies.

We would recommend that you consider alternatives to the generic approach, such as the BC drug plan, which considers not only generic substitution but does have provision for therapeutic substitution and has been somewhat effective in bringing drug costs back into line.

Within the Health Insurance Act changes, the minister is now able to determine unnecessary insured services. This means services could be removed from the OHIP schedule of benefits at the minister's discretion and, more importantly, without consultation.

This has significant implications, we think, for the health status of Ontario residents. Those who can afford it will be able to obtain delisted services. Furthermore, this government promised Ontario citizens that OHIP decisions would not be made behind closed doors and would become public input, debatable issues. We are concerned that the government is taking a path that would inhibit what it's promised: public input.

We would recommend that any changes to insured OHIP services and benefits, while they may be necessary, should be made in consultation with the health care providers and the public.

Pay equity is an important issue and it's again raised in Bill 26. The proposed amendments to this act remove the proxy method of comparison in determining pay equity in January of 1997. This provision was added to achieve pay equity for female workers in the broader public sector who were denied pay equity because there were no male comparators in the workplace. The elimination of this proxy indicates a lack of understanding or recognition of the relationship between income level and health status. Poverty and unemployment have considerable impact on illness and subsequent need for care. The largest bulk of people working in low-paid jobs are female. Pay equity is an attempt to redress this.

Since recent evidence suggests that poverty and unemployment are on the increase, we are very concerned that this policy change may be even more costly, again in human and financial terms, to the women in Ontario.

We therefore recommend a continuation of the pay equity amendment for those women who experience systematic discrimination.

Health human resource planning is indeed an important issue. The issue of supply, demand and distribution of health care providers is the subject of many, many committees. The nursing profession is quite familiar with fluctuations, especially in the need for nurses. Many of our 1995 graduates from the schools of nursing, prepared at taxpayers' expense, are currently not being utilized. The proposed province-wide hospital restructuring

signifies significant staff layoffs, not only of nurses but of other health care providers. As it stands, our system is currently preparing health care practitioners and then either not employing them or limiting their ability to practise fully, and this is not an efficient system.

Long-range health human resource planning must be a part of the larger picture of health care reform. This kind of planning considers present and future health human resource requirements and uses health care needs as the starting point. Once these needs and goals are identified, issues such as education and distribution can be appropriately dealt with.

We recommend, therefore, that system-wide, comprehensive and integrated health human resource planning be initiated.

Relatedly, it is logical that practitioners practise according to their full scope. One notable example of underutilization is the nurse practitioner. Freeing the nurse practitioner to provide care according to their full scope and ability allows the medical practitioner to attend to more complicated medical problems. The public can only win in a situation in which the appropriate provider is able to give the care he or she has the skill and expertise to provide.

On the issue of physician manpower, we believe it cannot be ignored. We must look at how many physicians we are preparing and how many people have guaranteed employment while underserved parts of the province continue to go without what's considered medically necessary.

We believe strongly that alternative payment mechanisms must be pursued for physicians. We believe that simply staying with fee-for-service is not an appropriate way to service the needs of the residents of Ontario across this province.

We also believe, however, that simply putting physicians on salary is not the answer. It is a very complex problem. Taking one, simple swipe of the pen and changing how physicians are paid will not go very far to redress some of the fundamental issues we have heard and have expert advice on as we move through underserved areas.

We would encourage the government, therefore, to set up a consultation to look at what needs to be done to encourage alternative forms of payment for physicians that look at blended funding systems and that will help to achieve more even distribution of the care across the province.

In conclusion, thank you again for the opportunity, and I would be pleased to answer any questions, if I may.

1530

The Chair: You've done a masterful job of using up your time, unfortunately, so there's no time for questions. But we do thank you for your interest and for your presentation this afternoon. Good afternoon.

Mrs McLeod: Mr Chairman, may I table a follow-up question to the Ministry of Health? It relates to schedule H, section 35, which would allow hospitals to charge insured persons for providing an insured service who are permitted to do so by regulation. Again, I would understand that any regulation under that would be currently in contravention of the Canada Health Act. I'd like the

Ministry of Health's opinion as to whether any regulations could be made under that section of the act that would not contravene the Canada Health Act.

N'SWAKAMOK NATIVE FRIENDSHIP CENTRE

The Chair: The next group is the N'Swakamok Native Friendship Centre. Welcome to our committee. We have Pat Rogerson. You have half an hour to use as you see fit. The floor is yours.

Ms Pat Rogerson: Thank you very much. I'd like to open my presentation by thanking you for this opportunity to present on behalf of the N'Swakamok Native Friendship Centre's concerns for the upcoming omnibus legislation, or Bill 26, as it pertains to health issues.

We would like to take this opportunity to recognize the role played by hospitals and health professionals in the treatment of disease and trauma in Ontario. Sometimes we forget that people are here trying to make a workable system work and we can sometimes lose sight and try to make people good guys and bad guys.

We would also encourage the recognition of the need for universally accessible health care for residents of this province without regard for individual ability to pay.

Most important is to note that both Ralph Nader and President Clinton reviewed Canada's health care system and found it compared very favourably on a cost for quality and quantity of service basis. In fact, the cost was considerably better than the costs found on the open market, especially due, they felt, to the efficiency of the administration processes. I'd like you all to keep that in mind when you're looking at health care changes.

Finally, the quality and the standards for service must not be jeopardized.

So what do we have here? We have a quality service provided by a variety of contractors whom we presently call physicians and public corporations we presently call hospitals, who deliver a universally accessible service at better than market value, and a province that feels it cannot continue to accommodate the costs of the health care system.

Decisions have to be made and plans have to be developed and implemented. This brings us to the impasse of today.

The environment as we know it is rapidly changing. Economically, sociologically, people and communities are facing rapid change fuelled by technology and science. In a time of change people often feel a sense of chaos and hope that increased power or control can be the answer. But whenever you're in uncharted waters, innovation is required, and this process of accommodating and directing within rapid change needs people to talk about pros and cons, it needs criticism, it needs support, but most of all time and energy to review and discuss. I have great faith in the democratic system, where the ebb and flow of analysis and discussion, criticism and complaint focus ideas, build answers, where regular and varied information is shared and interpreted. I fear greatly the focusing of more power and control in the Minister of Health's office. Regardless of political affiliation, no matter how far-seeing or wise that man is or can be, isolation in decision-making is especially dangerous in times of

change. I request—no, I beg—that this committee and the Ontario Legislature recognize the need to amend this bill significantly, especially where such tipping of the locus of power and control occurs away from the duly elected Legislature. Poorly informed decisions in health care can be deadly.

In relation to closing hospitals, the ministry must know that hospitals are not owned by the government. In fact, they are often owned by charities or churches or public corporations and foundations. As such, the government may choose not to fund them under its present legislation, but the government, despite whatever legislation they may enact, cannot close them. To justify the omnibus legislation of Bill 26 as a method to control hospital costs implies a plan to change the ownership rules in Ontario that's going to lead to a lot of legal wrangling.

With regard to physician services for underserved areas—of which, by the way, Sudbury is one—we need people who want to live and work in the north. I know many of us here find it hard to believe, but there are people who are emotionally and socially unprepared and unable to settle in northern Ontario. Forcing them to come here is not going to solve the problem. It takes a different attitude and different skills to survive here. We already know that people who are trained in the north in a northern-style program stay in the north and make excellent professionals. Open the training opportunities, and the underserved area problem will take care of itself.

In terms of health decisions, one of Ontario's most important and necessary health infrastructures is the district health council process. With support and processes that allow forced prioritization of need, health councils can provide locally made answers to problems and difficulties. Such a strong process must not and cannot be bypassed or made impotent, as regionally diverse needs and information are essential to effective planning.

We, as communities, have finally learned how to believe in and rely on health councils. This process is necessary to our community getting regional representation. Your legislation would close down their processes and would make one-size-fits-all solutions for Ontario.

An issue that I can't face each day, as a person, is the continuing erosion of my privacy as a citizen of this province. Everywhere I look, somebody else has access to private and personal information about me. No one has the right to invade my privacy, especially about my personal health. This is totally unjust. I have no alternative source of service.

When I did not like article 14 in the Royal Bank client card PIN contract allowing access to my financial information, I could go to the credit union and set up a whole new banking relationship based on different privacy standards. However, I can't do that here, can I? There isn't any other place to get health services. I can't find a medical system that recognizes my privacy needs if you don't.

There are methods of verifying service delivery without violating medical record privacy. Call the Auditor General; use the processes that are presently in place and available through regular privacy channels, the same as

every other insurance company in the world.

I would like to say that everything we do in this world is interconnected. Everything I do affects you, and everything you do affects me. We form a circle, and each part leans on the other. Health is not fixing what's broken; it's a way of living. If people can't find good food free from toxins and pollutants at a price they can afford; if they can't get clean air and clean water; if a vehicle is not safely built, operated or maintained; if people fill themselves with alcohol, cigarette smoke, fats; if there is no economically easy, accessible place to play and exercise, all the cost savings and all the corners you cut are not going to save health dollars, or not going to save tax dollars either. Good health is a way of life, and it's affected by the entire environment and everything we come in contact with and how we live.

To close, I've got several points I'd like to return to.

Health care must be universally accessible, with no barriers for those who are economically disadvantaged.

Decisions about our health care system have to be made with a maximum amount of information, debate and input through our duly legislated process, not by a Minister of Health working in relative isolation with one-size-fits-all solutions, especially in these times of really rapid change.

Underserved areas especially need committed physicians who know their patients and their communities and are willing to build those healthy communities, not just fix bodies.

1540

Health councils and legislative decisions and discussion are necessary to provide solutions to costly health issues.

Personal health privacy is a responsibility that you can't ignore because it's inconvenient.

Health is a way of life that needs to be supported and developed within a balanced circle of spiritual, emotional, mental and physical need. Each individual in that circle of the community impacts on the next. If the community is not healthy—clean air, water, safe places to play—then health is the ultimate problem, and one of the most expensive problems, that you're going to have to fix.

The Chair: Thank you. We have six minutes per party for questions, beginning with the government.

Mr Clement: Thank you for your presentation. You gave us a lot to think about and it was very well thought out. At the risk of derisive laughter from the other side, when I heard the principles that you just mentioned, I think the government agrees with you absolutely on each of those principles, and perhaps the two sides disagree on how best to get there. I sense that, but—

Interjection.

Mr Clement: Just a brief chuckle from Mrs McLeod. But I think the goals are worthy and it's a question of how we get there, where there is legitimate debate and reasonable debate and reasonable positions on both sides. It's very good for you to refocus us on where exactly we have to get to.

On a couple of those points, I just wanted to test the adequacy of some of the provisions of Bill 26 based on what you said. One of those things was local and public input. The way I read the bill, there's not really any mention of district health councils in the bill, which

means that the sections pertaining to district health councils are still valid and still exist because the bill is an amendment bill, it amends pieces of legislation, so that which we don't amend still exists. So the purpose of DHCs to advise and to plan locally, to get that input from the local community, to be representative of the local community and then to plug into what—we all must admit there still has to be some sort of provincial strategy to health care, I would hope. That still exists. Does that satisfy you at all?

Ms Rogerson: I think the role that health councils have played has been much stronger and much of the role that this legislation designates for the minister would usurp some of that control and power. It's not seen as direct control and power, but it certainly is a negotiation and a consensus-building process that makes the changes viable for that community. I have real concerns that those kinds of changes get lost when they go beyond our community and when the changes are in somebody else's hands.

Mr Clement: DHCs, to be fair, only have the power to advise, even under the current framework.

Ms Rogerson: That's correct, but when they worked well—and many of them worked very well in building consensus about how service would be delivered and who would deliver what service—then generally speaking, with a little bit of forced prioritization, support from the government, I think those processes could be used much more diligently than they are and would in fact reflect some of the things we need done without involving provincial-level changes that are imported or imposed.

Mr Clement: That's a fair point. I return to access to records, disclosure and confidentiality requirements, as I have done on several occasions today. I'd make the point once again that based upon my personal reading of the legislation, in fact, because the new legislation as proposed has some restraints or some conditions for which you are deemed to disclose your records, whereas the old legislation has no conditions—it just says you're deemed to disclose—I'm making a bit of a personal campaign to argue that the new legislation is more restrictive, more circumscribed than the old legislation. If that is in fact a valid view, would that allay some of your concerns?

Ms Rogerson: The legislation is very vague, okay? You don't have any policy or procedures going with it. It's going to be open to a lot of policy interpretation. I have some real concerns about the use of information about me personally. I've had a long history of fighting on this issue. In fact, I have changed banks because they wanted to be able to have access to that information. I think it's necessary for us to guard particularly health information, which can be very damaging to individuals and can limit their access to health services. So I feel it's really important that it be much more carefully written and I have major concerns about that. The legislation really opens some doors that I have some concerns about.

Mr Clement: We'll keep that in mind. You're from the native friendship centre. Is there anything particularly from an aboriginal point of view that you want to get across to us?

Ms Rogerson: Two things. I work with a community that is disadvantaged economically, and barriers to access

for health services in user fees or copayments are difficult in this community. I think it can lead to a much costlier result; it can cost a lot more in the long run when you deal with copayments. There has to be another way. I think if you talk to the pharmacy association, you will find that they have some alternatives in terms of having shorter prescriptions: that you try a drug first so you don't have leftovers etc before you actually assign a year's supply kind of thing or whatever it is you assign. Those kinds of things have a much better possibility of successfully saving Ontarians' money and I think it's important that they be explored.

Second, I come from a community where consensus-building is used to get the best decision and that public input and input from your community is most important to structure information so that you find the best answer to a problem. Anything that limits that in any kind of legislation is very discouraging, from our community's point of view.

Mr Miclash: Thank you for your presentation. At one point, you talked about retention of health care professionals in the north by opening up the training opportunities to them. Do you have any other suggestions for ways we may not only attract but retain health care professionals in the north?

Ms Rogerson: I've worked in this field in northern Ontario for a long time, and what I have found is that doctors generally are overworked. They have little chance to get a vacation or to get away from it all; they find themselves isolated with few or poor training opportunities, and they can't get away from their communities because they're often the only person there.

I would suggest that the provincial government may like to set up a doctor relief program similar to what they have in Britain or New Zealand where they traditionally had doctors who went in and gave doctors leave. As part of your payment back to the government for the investment they made in your training, you agreed to spend a year or two years doing locums, where you went in and gave the doctor two months off for his holidays or a month off or whatever, or allowed him to take a training course while you took over his caseload. That kind of program might possibly allow our doctors to survive in a much healthier way than they are now.

Mr Miclash: Pat, we hear a lot about government forcing health care professionals to relocate in certain areas, and of course I'm talking about the underserved areas. Can you comment on what that will do in terms of what you see in the health care area?

Ms Rogerson: I'd just like to draw your attention to a couple of the doctors we have here in town. Dr Sivers, Dr Garrioch and Dr Gluck are part of this community and have chosen voluntarily to be here. Each one of them takes part not only in their own profession but they coach hockey, they're involved in local fund-raising, and they're part of developing all sorts of local initiatives that make health care services better and that are more appropriate and responsive to this community. They make such valuable resources to our community that to lose them would be devastating, and we would never have gotten them if we had said, "You have to come to Sudbury for two years" or five years or whatever. They

would have come and been drop-in visitors for a year and be ready to leave.

1550

Mr Bartolucci: Pat, thank you very much for your presentation. I'm sorry I missed part of it.

The recent reduction in social assistance and in programs has had a major impact on many and in particular the friendship centre, which has been highlighted in the House by Shelley. Already people are not going to be able to cover the basic prerequisites of good health care such as food, clothing and shelter. The omnibus bill just heightens this inequity. Can you outline to the committee how it will heighten this inequity for the group you work with?

Ms Rogerson: The community I work with is mostly under 40. They are 75% female, and 60% of those females have children. For most of those women and young families, they're living in Sudbury to try to establish a new lifestyle for themselves. Over 10% of those people have returned to the reserve in the last three months because they can't survive here. That means they can't feed their children. They can't get jobs in this community because there aren't jobs for unskilled moms. Many of them were here to try to get education that would allow them to have the skills to compete on the job market, to give them an opportunity to open some doors for their children and themselves. For many of these women, once you go back, you never make it out again. We're losing a whole generation of people who would be able to make a change, to make themselves independent and able to get along.

I'm a great believer in prevention. I have worked very hard over the last few years to build a prevention program designed to make people stronger and better able to take care and control of their own lives. We deal with about 2,000 young people a year traditionally who have had improvement in skills in anger management, cooking skills, nutrition, budgeting, careful buying, all those good things; also the social skills, the ability to deal with people, to meet people in both the native and the non-native community, to handle job interviews, to send out résumés. We no longer have the programming that deals with that. Those programs have been cut.

I have kids sitting in my office who are saying: "Pat, what do you want us to do? My feet are making the choices again. I'm going to get into trouble." When I say, "My feet are making the choices," I mean that we used to map the community and say: "Where are your support systems? Where are the good things that are going to happen? Go there. The bad things you know about. Make the choice with your head when you're leaving your house, instead of your feet." Our YOA offences have gone up. Our youth facilities were all full over Christmas. Things are really tough here.

Ms Martel: Let me follow up on part of Rick's question and talk to you a bit about copayments. You didn't mention that, at least while I was in the room. You've got a lot of folks who come into the native friendship centre, about 500 people who come in every day for service. I suspect some of those folks are on social assistance who will now pay a \$2 copayment.

Given the cut in funds they've already achieved, if

they haven't already made a decision to return to the reserve because they can't afford to stay in the community, how long do you think it will be before some of those moms take their kids back because they now can no longer afford to deal with copayments and drug costs that they didn't have before?

Ms Rogerson: One of the things that will happen is that moms will not be able to look after the medical needs of their children, particularly if those moms do not have status. About half our population is non-status. We have about 14,000 aboriginal residents in this district. If half of them are non-status, if 75% of them are female with young children, you're looking at the kind of response that is really devastating.

If you just look at the cost of antibiotics, our children are much more susceptible to all the diseases that are available for everybody to catch. Our kids also get a lot sicker. Most times, if you have measles your kids get pneumonia. Most times, if they get chicken pox it develops into a whole host of other things. We're looking at kids who get really sick from minor ailments. If you can't get to the druggist and get yourself a prescription because you just don't have that \$2, what happens is that your child goes into the hospital.

Mr Howard Hampton (Rainy River): I noted that you are concerned about protection of patient privacy. Mr Clement is the only person I know who says that this is not an interference with privacy. In fact, the Information and Privacy Commissioner of Ontario has publicly said that he's very concerned about these sections. I think you're on better ground with the privacy commissioner than you are with Mr Clement.

I wanted to ask you about that, because I think the health records and the patient information stuff here has more to do with the government's rhetoric than it has to do with the reality of health care, and I'd be interested in your views. The government has put out a lot of rhetoric that people are defrauding the health care system, they're defrauding the WCB, they're defrauding social assistance. They're trying to create this aura of fraud. I really think this being able to grab your records, your patient information, has more to do with that rhetoric than it has to do with the reality of health care for people. You work with people. I'd be interested in knowing your views.

Ms Rogerson: Generally speaking, my experience has been, in Sudbury anyway—and I don't work in the rest of Ontario so I can't speak for the rest of Ontario—that our population is relatively law-abiding when it comes to use of services. There's a feeling in this community of regret and concern that anyone would cast further aspersions on the users of services. They have enough to carry without carrying the extra load of supposed guilt without proof.

We had a snitch line in Sudbury for welfare recipients and that snitch line netted us, I'd say, about 400 times the number of names. After investigation, the snitch line netted us 27% fewer convictions. The names were given because people didn't understand about services, didn't understand about what you were allowed to do under the legislation of the time, didn't understand that you could work and so long as you claimed it and told your welfare worker that you were working, it was permitted. They

didn't understand that if you had child care you could get that child care paid for and still be on welfare. A lot of the reports were lack of understanding.

A major proportion, unfortunately, were grudge reports or abusive husbands who were trying to make it impossible for wives to leave home. It was a very sad situation for us to review, but it was certainly very clear when it was reviewed that this didn't surface a whole lot of fraud. It surfaced less than 0.03% in Sudbury. Most insurance companies feel that a 5% fraud rate is tolerable, and if you have less than that it's not worthwhile financially and legally, in terms of costs, to go after it.

The Chair: Thank you, Ms Rogerson. We appreciate your involvement here and your presentation.

SISTERS OF ST JOSEPH OF SAULT STE MARIE

The Chair: Our final presenter is Sister Winnifred McLoughlin, representing the Sisters of St Joseph of Sault Ste Marie. Welcome to our committee, Sister. You have our last half-hour. Questions, should you leave time for them, would begin with the Liberals.

Sister Winnifred McLoughlin: Good afternoon. As you know, my name is Sister Winnifred McLoughlin. I am the health care coordinator for the Sisters of St Joseph of Sault Ste Marie, and I'm here this afternoon representing our general superior, Sister Mildred Connelly, who was unable to attend due to the short time frame for presentations here today.

We are a religious congregation that has been involved in the delivery of health care in the north since 1884. We have worked in communities from Thunder Bay to North Bay and in all areas of the health care ministry, including acute care, rehab, long-term care, addiction treatment programs and community-based services. Our role has changed and evolved as the needs of the communities we serve have changed. Today we continue to sponsor hospitals in Sudbury, Elliot Lake, Blind River and two facilities in Thunder Bay.

Our hospitals were initially staffed with sisters, a few lay nurses and student nurses. A great deal has changed since then. Today, many lay people have joined the sisters in the hospitals and other health care facilities sponsored by my congregation. In 1960, with the advent of universal health insurance, the government began a partnership with religious communities. This system was designed to provide health care services to the public, and was not intended to compromise the rights of religious congregations and the church to witness Catholic values in health care.

1600

With respect to Bill 26, we understand and clearly appreciate the desire to control health care spending and that the way to do this is through restructuring. While we are supportive of restructuring to eliminate duplication and to provide effective and efficient service delivery, we are also mindful that we must ensure that the proposed legislative changes allow denominational providers to continue to play an active role in the health care system.

As has been the case in the past, we feel that the rights and responsibilities of local communities and providers must be balanced with the powers and authority of the

Minister of Health as we strive collaboratively to restructure health care and meet the economic challenge that we are facing in Ontario today.

The partnership between government and denominational providers has meant that the Catholic health ministry has become an important contributor to Ontario's health care system. Across the province of Ontario, more than 30,000 people are employed in Catholic-sponsored institutions and the hospital sector alone accounts for \$1.3 billion of the \$7.5 billion to \$8 billion spent annually on hospital care in Ontario.

However, the Catholic health care ministry is not really about numbers of employees or billions of dollars. It is about health care that is rooted in the ministry of healing that is a fundamental aspect of the Catholic church. As a group of religious women, this has been an important part of our commitment. In the communities where we have been invited to serve, we have a history of shaping and reforming health care to meet changing needs and priorities. We have long understood the need to control health care spending through restructuring and have voluntarily engaged in efforts to improve health care across the north.

For example, in North Bay in 1984, when it became clear that there would only be sufficient funds to rebuild one facility, we entered into a 10-year process to voluntarily withdraw from hospital-based care in order to ensure that the scarce dollars available would not be wasted on duplicating services and infrastructures. In Elliot Lake, we saw the need for an alcohol treatment centre and expanded chronic care services, while in a smaller community, such as Blind River, we recognized that our efforts should be focused on community-based and outpatient services rather than trying to rebuild an acute care setting that would never be able to provide the range of services available in a larger centre, such as Sudbury.

In Sudbury, long before government-initiated restructuring began, we recognized that our expertise had developed in acute care and the infrastructure and support services that are necessary to deal with the provision of care 24 hours a day, often under traumatic and tragic circumstances. Out of respect for the expertise of other providers in our system, we entered into a partnership with Network North, the community mental health group. This required the voluntary transfer of responsibility for our mental health services to them. We also identified a number of additional programs that other facilities could better provide and had offered to transfer responsibility for these programs to them. We also entered into a number of voluntary partnerships and shared service arrangements as interim steps to achieving the much-needed realignment of programs.

In Thunder Bay we have recently decided to cease providing a number of duplicated acute care programs and concentrate instead on rehabilitation and long-term care. Therefore, in that community we have been able to focus on developing a continuum of services that include rehabilitation clinics, EAP services and a nursing home.

To ensure the future viability of our health care ministry, we have expended great effort to transmit the depth of our commitment to the laity with whom we

work, such as our administrative staff, board of trustees and front-line workers. As I have clearly indicated, our facilities have been responsive to the communities wherein they operate. This is due in large part to our governance structures which allow us to achieve the goals of our ministry while working with representatives of local communities and government. Through representative and voluntary boards of trustees, our Catholic health institutions and community-based services are good stewards of scarce financial resources and are anxious to find ways to eliminate unnecessary duplication and to bring about progress and change in Ontario's health care system.

Our commitment to restructuring has been based on the philosophy that a great deal can be done voluntarily when people come to the table with goodwill and respect. Unfortunately, we also know that there are situations, such as occurred in Sudbury, when government-imposed restructuring has deteriorated into a struggle for power and control that results in attempts to eliminate the denominational provider by using a focus on governance rather than patient care. Objectively, there are some in the community who believe that the only way to improve patient care is to have one governance structure or one board. We know from our success across the province that this is unnecessary when people are motivated by community need and patient requirements.

We commend the government for acknowledging that patient care improvement and efficiencies can be achieved with more than one governance structure in place. We agree that what is needed are the tools to cut through the destructive politics that have divided a community such as Sudbury and that we hear are also occurring in communities such as Pembroke, Windsor, St Catharines, Chatham, and perhaps will likely occur down University Avenue where the denominational facility is being threatened by proposals for one board.

Based on the involvement of the Sisters of St Joseph in hospitals across the north, I can come here today and tell you first hand what happens when a community focuses too much on form and structure rather than on the functioning of the system.

First, on a positive note, in Thunder Bay, as I have already mentioned, the community decided to divide the provision of services by grouping related programs and building on areas of expertise. The implementation of this plan is now proceeding.

In Sudbury, however, despite similar recommendations 10 months ago by the hospital services review committee that programs should be realigned to minimize duplication and maximize efficiency, there has been no progress in implementing the report. This is because in Sudbury the focus has been mistakenly placed on the form of the system rather than its function. The Sudbury community has been divided by debating structure, form and governance. Meanwhile, change is not taking place, economies are not being achieved and the elimination of duplication and improvements in care have been delayed.

One of the reasons I am here today is because, as a religious congregation, we must be vigilant that proposed legislative changes do not threaten the continuation of our health care ministry. Under the proposed changes to the

Public Hospitals Act introduced by the NDP government, we experienced extreme concern that traditional voluntary governance structures would be eliminated, and consequently our opportunity to fulfil denominational health care ministries would be removed forever.

We are extremely pleased that prior to the last provincial election, each of the party leaders committed to preserving and enhancing denominational health care. We have been very reassured to date by this government's affirmation that denominational hospitals and their boards do not need to be eliminated in order to achieve the goals of health care reform. There has been a positive recognition of both the historic and future contribution to be made by facilities such as those sponsored by my congregation. In Sudbury, we have appreciated Mr Wilson's assistance in defusing the misuse of governance and the resulting abuse of denominational providers. By emphasizing that the restructuring plan could proceed without change to our hospitals' governance structure, the minister's directions have been extremely valuable.

1610

I must say that, based on the local Sudbury reaction to the minister's very clear direction that the restructuring plan be implemented, and the continuing stalling that has occurred, we well understand the need for a different set of tools to enable the process to move forward as quickly as possible. The benefits of restructuring would then be realized by our patients sooner rather than later. We welcome the establishment of the restructuring commission and are pleased to hear of the Health minister's commitment that this will be a time-limited mechanism to implement approved restructuring plans. To date, we have been reassured by the commitment of the minister that this commission will not be used as another way to threaten the continuation of the denominational ministry by eliminating or marginalizing our role or that of our boards.

By using our approved restructuring study as the blueprint for implementation, this government has reinforced that patient care improvement must be the motivation for all hospitals. For this reason, we feel it is important that the regulations only allow the implementation of plans that have been approved by the Minister of Health. While some fine-tuning may be necessary as final implementation details are worked out, we must caution against any regulations that would allow the commission to be lobbied to change their outcome. Not only would this further delay implementation of much-needed restructuring, but based on our experience in Sudbury, we feel that any such latitude could also provide another venue for attacking denominational health care and voluntary governance structures.

It is important that the members of the commission understand, as the government and the leaders of the opposition and third parties have, that the corporate integrity of Catholic and denominational hospitals must be protected. Our mission focuses on holistic care which embodies the physical, emotional and spiritual needs of patients. It is a ministry that is available to all, regardless of creed. In all of our efforts, the dignity of the person created in the image of God and re-created in the image of Christ is paramount. While we make no claim that

such aims are exclusively Catholic, we insist that Catholic health care must embrace these components.

I know that the Catholic Health Association of Ontario will be making a presentation to this committee on behalf of all congregations across the province. We of course share many of the same concerns about certain aspects of this bill, particularly the uncertainty around the regulations that will accompany changes to the Public Hospitals Act. We trust that the regulations will respect the commitments made to the CHAO and its member hospitals to preserve the corporate structures of Catholic and denominational hospitals now and into the future. We also support the OHA's position on the need to respect ongoing voluntary governance.

We do, however, believe that if the extraordinary measures contained in this legislation are limited to the period of time it takes to accomplish restructuring, they will go a long way to ensuring that communities have the opportunity to develop plans to meet their future health care needs. They will also see their efforts bear fruit as these plans are implemented.

In order to respond to the financial challenge in the short time frame available, the power to transfer funding, merge and close hospitals is necessary to offset the politics of isolation or domination, or, in the case of our recent experience in Sudbury, the attempts to eliminate denominational providers. By aligning funding with service provision, as recommended in restructuring studies, this tool will return all providers to the focus on patient care improvements and community service.

In Sudbury, these powers could be used to immediately establish the new reality called for in our study, a two-hospital system. We would encourage a merger of the two public corporations, as has occurred in Thunder Bay, Windsor, London and is being planned for in Metro Toronto. This is the fastest way of implementing our study and provides the opportunity for expanded cooperation and collaboration between the public and denominational corporations while achieving the economic objectives that Bill 26 sets out as imperative.

We are called to be advocates of due process and fair and equitable treatment for all. In cases where a supervisor is appointed for reasons other than implementing restructuring, we would support the incorporation of some due process which involves a response from the minister. However, based on our experience in Sudbury, we cannot support further opportunities for appeal by those who have intentionally obstructed and resisted the implementation of our approved restructuring study. Having a 30-day or 60-day due process opportunity to rationalize these actions will only allow further unwarranted delay.

For this reason, we believe that the minister should have the authority to appoint a supervisor, once the community's plan has been endorsed by the minister, if no progress is made in implementing the plan within a reasonable period of time. Failure to come to the implementation table in a supportive and cooperative manner would be grounds for such action. Without this type of authority, numerous hours and much effort can be wasted dealing with attempts to derail less popular aspects of studies. As with the restructuring commission itself, we support the recommendation that this expanded criterion

for the appointment of a supervisor should be time-limited ending March 1999.

Voluntary arrangements always seem to work the best. Based on my congregation's experience across the north, we believe that there is a variety of collaborative arrangements that can achieve the objectives of hospital restructuring while respecting corporate integrity for those who wish to see their missions continue. In all the communities where we sponsor health care facilities, we are committed to working with the government to reform and restructure our system and to ensure that real change takes place. We also look forward to the continuation of the tradition of denominational hospitals thriving in an atmosphere of pluralism and tolerance, characteristics which are an important part of this province's strength.

The Chair: Thank you, Sister. We have three minutes per party for questions, beginning with the Liberals.

Mr Bartolucci: Sister, thank you for your presentation. You agree with the restructuring commission, certainly, that's clear, but should the restructuring commission only implement the decision of the minister or should it have the power to merge or close hospitals?

Sister McLoughlin: I would think they should have the power to implement plans that have been approved by the minister. That follows after a lot of study with community involvement.

1620

Mr Bartolucci: So we're not excluding the DHC in the process?

Sister McLoughlin: No. The DHCs make the recommendations if they're the ones charged with conducting or being responsible for a study that is carried out.

Mr Bartolucci: Very briefly then, could you just clarify for me—we know the reason for the DHC—how does the commission fulfil its mandate if there is no communication between the commission and the DHC? In other words, if there is to be communication, what types of regional mechanisms should be in place to ensure that this happens?

Sister McLoughlin: I think that if there is an approved implementation study that the DHC has recommended to the minister, they would collaborate with the commission in the implementation of that study. So I would think there would have to be regular meetings if there were a misunderstanding or a need for clarification.

Mrs McLeod: Just following up on what Mr Bartolucci was asking, I would gather then that you would have some concerns about the minister's ability to delegate the responsibility for making decisions about the supervision of hospitals, or indeed the closure and merger of hospitals, to someone other than the minister himself.

Sister McLoughlin: Yes, I think that should rest with the minister.

Mrs McLeod: I appreciated the very positive orientation you put into the presentation that you made today. I wish that in all the restructurings that are going on in communities, it could be taken as the fundamental guideline that we look at function rather than form.

Even in Thunder Bay, where I think we have made real progress in resolving some of the governance issues, and particularly the issue of denominational governance in acute care, other new governance debates seem to

emerge in terms of who owns businesses. If we could just keep it on function and what's best for the community, a lot of the divisiveness could be resolved.

Sister McLoughlin: Yes.

Ms Lankin: Thank you for your presentation. We appreciate your presence here and the information that you've brought before us. I also wanted to follow up on this issue of the restructuring commission.

I should tell you that I am not convinced it is a necessary structure. I agree that it is necessary for the minister to be able to implement the approved plans of district health council local planning. I'm not sure why a commission is necessary, as opposed to the ministry and all of its structures that are already there. I would be interested in what thoughts you might have on that.

I also agree with you completely that the process of local planning should in fact be one that is led through a district health council or similar process in that whatever the minister, or a commission, if that's the case, implementations should be whatever the approved version is coming out of that kind of report. I would like to see some amendments to the legislation that build in some linkage between the commission and the DHC. Would you support a move in that direction for amendments?

Sister McLoughlin: Yes, I would, and I also feel strongly about the commission because of our difficulties here in Sudbury.

Ms Lankin: Could you tell me what a commission would do that the powers of the minister can't?

Sister McLoughlin: In Sudbury he had to tell the DHC five times that governance was not an issue, that restructuring should go ahead regardless of governance. I really question then, if the minister didn't have that power, could another group be given the clout to do it?

Ms Lankin: That's my point.

Sister McLoughlin: I don't know but it has been a horrific year for us and we are just looking at some solution that would put an end to all of this political interplay.

Ms Lankin: Lastly, I just wanted to make a comment and perhaps correct the record. Unless my memory's very faulty, at the point in time, under the previous government, that there were discussions of changes to the Public Hospitals Act—I was the Minister of Health, it was a few years ago and I might be wrong about this—but I believe we didn't introduce changes to the Public Hospitals Act. We did publish a report which was done as the result of a lengthy consultation with a lot of people, and I know the provision that you were most concerned about was a proposal to elect local hospital boards.

In fact, after lengthy consultation we decided as a government not to proceed with those changes or any changes to the Public Hospitals Act at that time. That consultation took place over a long period of time,

considerably longer than the two months we have to deal with this huge bill.

So I just wanted to set the record straight that sometimes ideas come forward from a process of consultation, and then when checked back with people, governments make a decision based on the input they get not to proceed. I'm hopeful that this government, based on the input it's heard over the course of these hearings, decides not to proceed with some of the measures of this bill.

Mrs Ecker: Thank you very much, Sister, for coming forward this afternoon and providing your very well argued case. As someone who's had some familiarity with the quality of care in denominational hospitals, I certainly can understand where you're coming from.

I would also agree that voluntary is best but that, as is indicated in Sudbury, sometimes a community, despite its best efforts, needs someone, from the government in this case, to try and resolve it. I know in my own community we've had a similar problem, where the district health council had gone through a process, we had recommendations and we needed some influence by the minister to try and keep things going along.

Where you probably hit the nail on the head—there has been a fair bit of debate about whether there should be the power with the minister to close hospitals or whether it should be with the commission to close hospitals. I think that the minister's commitment, first, is that it's very clear that the district health council recommendations would be the basis for restructuring.

But second, his concern is precisely, as you mentioned, the political interplay, the politics that start to get into the restructuring and hospital decisions, and his recommendation, his suggestion, was that the commission would somehow, by taking one step removed from the minister, perhaps eliminate that problem. Do you see that as being perhaps hopeful in that way?

Sister McLoughlin: I would be hopeful that this would be the process that unfolds, but I think the ultimate responsibility will rest with the minister.

Mrs Ecker: Ultimately. Okay.

The Chair: Thank you, Sister.

To the people of Sudbury, thank you very much for your hospitality. We've enjoyed our time here and we'll come back some day.

Ms Lankin: Are you going to vote in favour of my motion, Mr Chair?

Mr Bartolucci: The OMA has presented a very excellent brief. Although they didn't get on the agenda today, as I know they wanted to, I would certainly encourage the committee to read their presentation very carefully, as it contains excellent recommendations.

The Chair: Thank you, Mr Bartolucci. We will now adjourn to Mrs McLeod's favourite place, Thunder Bay.
The committee adjourned at 1628.

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

Marchese, Rosario (Fort York ND)

Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Johns, Helen (Huron PC) for Mr Danford

Miclash, Frank (Kenora L) for Mr Sergio

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

Bartolucci, Rick (Sudbury L)

Brown, Michael A. (Algoma-Manitoulin L)

Hampton, Howard (Rainy River ND)

Martel, Shelley (Sudbury East / -Est ND)

McLeod, Lyn (Fort William L)

Ramsay, David (Timiskaming L)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Campbell, Elaine, research officer, Legislative Research Service

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**Standing committee on
general government**

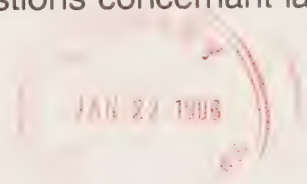
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Health issues

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Wednesday 10 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Mercredi 10 janvier 1996

The committee met at 0900 at the Airline Motor Hotel, Thunder Bay.

SAVINGS AND RESTRUCTURING ACT, 1995

LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): As is our custom, we're going to try to get started on time, if I could get you all to take your seats, please.

To everyone in our audience, we're delighted you're here. We appreciate your interest in the process. I'd just like to remind you that the dialogue is between the presenters and the committee members and we'd kind of like to keep it that way.

THUNDER BAY REGIONAL HOSPITAL

The Chair: Our first group this morning represents the Thunder Bay Regional Hospital: David Ringius, chair of the board, and Gaston Levac, president and CEO. Welcome, gentlemen. You have a half-hour to use as you see fit. Questions, should you allow time for them, would begin with the New Democrats. The floor is yours.

Mr Dave Ringius: Thank you. I am Dave Ringius and I will make the presentation and both of us will answer questions.

Thunder Bay Regional Hospital is pleased to present our corporation's comments on Bill 26. We commend the finance and economic affairs standing committee of the provincial Legislature for providing interested groups and individuals with the opportunity to present their views on this proposed legislation.

A little bit of background: Prior to commenting on Bill 26, we believe it is important to provide the members of the committee with a brief description of the new Thunder Bay Regional Hospital Corp.

The Thunder Bay Regional Hospital Corp was established on April 1, 1995, through a voluntary amalgamation of the former Port Arthur General Hospital and the former McKellar General Hospital. The establishment of this new corporation was totally compatible with the Thunder Bay Hospital Services Review Report (1993-94) which recommended the creation of two hospital busi-

nesses for Thunder Bay. One business focus would include all acute care services, with the other being responsible for comprehensive chronic and rehabilitation services. The Thunder Bay Hospital Services Review Report recommended that all institutional hospital services be contained within these two businesses. It was further recommended that these distinct organizations be governed independently by their own boards with separate management structures, a vast improvement to a system previously comprised of five hospital corporations, each with its own board and management structure.

With a mandate to be the only acute care regional referral hospital corporation in Thunder Bay, the board of directors, the management, the medical staff and the employees of Thunder Bay Regional Hospital have the following goals:

- To consolidate all institutional care services under one corporation, with one management team, one medical staff and, in the medium term, on one site; there are currently three sites.

- To utilize the achievement of increased efficiencies to enhance the quality of institutional care in our community and our catchment area.

- To work cooperatively with other health care providers, including our district health council, to ensure that our actions continue to be consistent with the Thunder Bay Hospital Services Review recommendations.

- To decrease the overall cost of providing institutional care services in Thunder Bay.

- To reinvest part of the savings accrued through this restructuring of acute care services in enhancement of weaker programs, such as our trauma program; establishment of non-existing services—several home support services; improved recruitment and retention of health care specialists; consolidation of all institutional acute care on a new hospital site within five years.

We'd like to highlight the progress achieved in just a few short months, the magnitude and pace of which we believe were only possible because of a true amalgamation. With widespread community support for the need for change and by starting quickly to implement change, our initial steps in reorganizing to increase efficiency, improve quality and reduce operational costs have already resulted in an annual decrease in operating expenses of \$2.1 million on a total budget of about \$95 million. Discussions on plans for further changes are well under way. Obviously, the recent funding reductions announced by the Minister of Finance will add significantly to our challenges.

We believe that similar opportunities are available to all multihospital communities if meaningful restructuring occurs. We also hope that communities that have shown

and indeed have taken the initiative to implement changes such as we have done at Thunder Bay hospital will not be penalized down the road.

We also make the following observations:

Many communities or transfer payment agencies currently opposed to Bill 26, in some way, contributed to the province's financial problem.

Many communities/TPAs have been unwilling or unable to achieve consensus on the measures which must be taken to assist the government in balancing the books. On the contrary, almost the entire public sector, including transfer payment agencies and many special-interest groups, has continued to lobby governments for more transfer payments or for the status quo over the years.

Most communities/TPAs currently have no concrete proposals to assist the provincial government to balance the budget and to significantly reduce the level of existing transfer payments.

The provincial government has a responsibility to the electorate to make significant changes in legislation that will empower it to impose measures, when necessary, upon communities and transfer payment agencies to achieve a balanced budget.

Our position on Bill 26:

Firstly, we support the government's agenda to balance the provincial budget within its first term. We believe that the long-term viability of our province, of our country and of all our public services depend on it.

Secondly, we support the government's agenda to reorganize the entire public sector service delivery system to make it more efficient and to provide public services within our ability to pay and within our ability to sustain them within a balanced budget.

Thirdly, we support the government's thrust to divest itself of the direct responsibility for delivery of services wherever it can do so to save tax dollars.

Fourthly, we wish to indicate our general support for Bill 26 giving the Ontario provincial government the powers and the tools to achieve its stated agenda, for which it was elected. We acknowledge that the government's primary mandate of balancing the provincial budget cannot be realized without appropriate changes in legislation to allow the government to take dramatic measures when they are clearly required to be taken.

However, the powers to be assumed by ministers, the civil service and boards that may be appointed to implement or enforce actions taken under the bill are overwhelming and somewhat frightening. Therefore, in requiring Ontarians to accept this legislation and its inherent powers, the government, its ministers, civil services and boards must strive to attain much higher standards than we historically have seen from them in the past. Parochialism can have no part in implementing this bill if this government expects the people of Ontario to readily accept the provisions of Bill 26.

Some proposals to improve Bill 26:

We believe that most Ontarians support the intent of Bill 26, and such support should be enhanced with the following considerations. Our suggestions focus on conditions for utilizing the powers outlined in the bill, on sunset clauses and on the role of the civil service in the implementation of the act.

We recommend that the provincial government provide written descriptions of the conditions which will need to occur in communities or with the various transfer payment agencies prior to implementing the new powers in the proposed legislation. Examples of such conditions may include:

—When consensus has been achieved that communities or TPAs are incapable or unwilling to meet provincial goals or norms which are being created by or progressively agreed upon by other Ontario communities or other transfer payment agencies—"consensus" could be defined as agreement reached in communities by a majority of stakeholders and the appropriate minister of the government upon advice of any commission he or she may establish;

—When there is consensus that communities or transfer payment agencies are unable or unwilling to achieve goals within reasonable time frames coestablished with their respective ministers;

—When there is consensus that the measures being taken by communities or TPAs to meet provincial financial goals are being implemented in ways which compromise the quality and/or the long-term viability of those services or the desired increased and sustained efficiencies.

0910

We recommend that the provincial government provide pre-established sunset clauses as to how long a minister may assume extraordinary powers through legislation, such as:

There should be an overall sunset clause to the legislation itself subject to the province's financial goals having been achieved and/or subject to a broad provincial evaluation process of the effectiveness/need for such legislation once a balanced budget has been achieved and the appropriate structure to sustain it is in place.

A minister would only assume extraordinary powers over a community or a transfer payment agency for a maximum of six months, after which time the responsibility/authority and accountability would revert back to the community or the transfer payment agency via a community board or a body established by the minister in consultation with appropriate local stakeholders.

We recommend that the provincial government provide safeguards to ensure that civil servants from the various ministries respect the intent of the legislation by:

—Providing interpretations that respect the spirit of the legislation.

—Not providing interpretations that strive to protect their own status or promote their agenda.

—Preventing civil servants from implementing the legislation whereby the responsibility and accountability for implementation of the government's agenda is removed from the appropriate communities or transfer payment agencies and retained by the civil servants. Communities or transfer payment agencies are much more likely to be successful in their support for the government's goals if the ways and means of doing so are retained by them rather than vested in the civil service.

In conclusion, the Thunder Bay Regional Hospital supports the need for a balanced budget in Ontario:

—Encourages the provincial government to proceed with legislative change and to utilize these powers prudently as recommended above;

—Encourages the government to resist being influenced by the doom-and-gloom rhetoric of communities/transfer payment agencies/special-interest groups. We all share the responsibility for our current financial problems and we all must be an integral part of the solution.

—Emphasizes the need for the government to ensure communities/transfer payment agencies which have already initiated the process of restructuring that they will not be penalized down the road.

The Thunder Bay Regional Hospital will continue in its efforts to contribute to a balanced provincial budget.

Respectfully submitted by the Thunder Bay Regional Hospital Corp.

The Chair: You've allowed about six minutes per party for questions, beginning with the New Democrats.

Ms Frances Lankin (Beaches-Woodbine): I must say, as a former Health minister, it warms my heart to hear a hospital board chair and CEO—and we've heard it in other communities—come forward and be so supportive of the need for restructuring. Would that I'd had that kind of cooperation a few years ago. But I have to say that M. Levac was always one, in my dealings with him in Sudbury, to be very supportive of the need for the change and the restructuring. I appreciate your comments on that.

I'm particularly interested in the conditions that you've set out as examples of what should be put in place prior to some of these extraordinary powers being used by the minister. I think that is very helpful. I also note that you're saying you want to see a sunset clause to the powers, and I heard you say, I think, to the legislation overall once the goals have been achieved. This is a pretty simple question, but I assume from that that the minister's commitment to sunset the restructuring commission doesn't go far enough for you at this point in time, that you think the sunset clause needs to be more broadly applied.

Mr Ringius: I think we have to make sure and be aware that as we progress, the accomplishments that have happened should vest in the community and not with the central powers. So we would like that to have a sunset clause so we can determine when they're no longer involved.

Ms Lankin: Just in terms of some of the powers that you're talking about, I would assume the appointment of a supervisor and the supervisor's powers and those sorts of things, but what about the ability of the minister to impose a physician human resource plan on the hospital? I've heard that referred to by some other hospital representatives as they fear the potential for micro-management and they would like to see that sort of power sunsetted as well.

Mr Gaston Levac: I think the overwhelming or fundamental approach to the comments that our chairman has just made is that obviously, if a community is able to resolve restructuring issues on its own and that restructuring effort is compatible with the overall provincial goals of balancing the budget and doing things differently in a way that we can sustain in the future, then the commis-

sion would have less of a role and our discussions on the fine print of sunset clauses and conditions of using the powers would be less important. However, the experience in Ontario has been that such a commission is necessary, because many communities cannot achieve consensus, and even where there has been consensus, such as Thunder Bay, there are still unresolved issues that may well require the intervention of a central body with the power to say, "This is what we would like to see, based on the overall provincial framework and the overall provincial goals."

The long answer to your question is, the sunset clauses and all of the peripheral elements to the initial intent of the legislation are less important than a clear, sound judgement about when it's appropriate to use the powers and in what circumstances.

Mr Gilles Pouliot (Lake Nipigon): Welcome. I listened—we all did—intently. No less than five times, with respect, David, you have mentioned the need to balance the budget grosso modo. The province takes in some \$47 billion per year. The province spends \$10 billion more, some \$57 billion. You have also mentioned that it must be done within a term of office. With the tax cut, for we have to believe what has been said, you add another \$5 billion. So are you suggesting—because I did not, with respect, hear anything about the tax cut, which is another \$5 billion, but I heard five times the need to reconcile the books, to balance the budget—would you subscribe to \$15 billion less money being injected in Ontario society when you, sir, provide the most essential of services, that of health care, not only for Thunder Bay, but for the region?

Mr Ringius: I believe that we're all responsible for the deficits, because of demands we've made on governments in the past. We at some point have to recognize that there is a need for change. The time frame that we're recommending here, because of the sunset clauses, has to be within the term of the current government. It is our hope that they will balance the budget in that time frame, and we will also make the appropriate accommodations in health care restructuring services. We have an aggressive agenda in Thunder Bay to make sure that we have health care at the bedside, that we will continue quality care. We have a history of getting things done voluntarily in Thunder Bay. We believe that is accomplishable within that time frame. Whether or not that includes tax cuts, that's not my determination; that's up to the government. We're here to make sure that we deliver the best possible health care for Thunder Bay.

Mr Pouliot: A 30% tax cut—if I had the choice, and I'll be candid with you, I could forgo that, providing that your doors, for the people I represent and me also, remain open. It's a choice I have to make. I too wish to balance the budget, but what we have here is a supplementary burden of some \$5 billion because someone, simply put—and I know you don't wish to say this, but I can and I will—went out on a limb to gather votes, and why not?—and now is stuck with a 30% tax cut, and the economy isn't growing, plus the determination to impose another \$10 billion, all this in a very limited, very systematic and deliberate time frame. We say it can't be done because we begin to dislocate.

The Chair: Thank you, Mr Pouliot. For the government, Mr Clement.

Mr Tony Clement (Brampton South): Thank you very much for your presentation. I was avidly listening to your suggestions for improvement because we are looking for improvements to the bill as we go through our hearings process. I just wanted to come back to a couple of the points that you had mentioned and to draw out a bit for the purposes of our committee some of the conclusions that we can reach together.

I take it then that the hospital's position is that there has to be an ultimate decision-maker and that ultimate decision-maker is the minister. Is that fair to say, where you're talking about hospital restructuring?

Mr Ringius: Where the community has been unable to reach consensus in an appropriate time frame, we believe that there needs to be a global body that makes these decisions, to get on with the change and restructuring that's required in order to balance the budget.

0920

Mr Clement: So it's almost like a hierarchy, then? The first stage of the process would be a local process, a community process. That would then be part of the district health council, presumably, and the hospitals would have input into that and community stakeholders. Then it goes, I guess, under our proposal, to the restructuring commission, but it would have to be cognizant of what's going on in the community and the community's, I guess, wishes, if it can be discerned what those community wishes are. Is that fair to say?

Mr Levac: The short answer is yes, but if I may be permitted a few additional comments, I have the privilege of wearing another hat in my current role. I currently chair the Canadian Health Care Association, which is the former Canadian Hospital Association, so I have a fair perspective of what's going on across the country, having the 11 provincial associations for hospitals as our members.

I can say pretty definitively that most provinces where there has been some form of legislation providing a provincial framework for change in order to meet the provincial government's goals have initially resisted that and found those pieces of legislation to be offensive. But what I'm witnessing over a period of three or four years since this type of legislation has been introduced in various provinces is that in retrospect people feel it was the best thing that ever happened to their provinces, because it did provide a sense of direction, a sense of leadership and a sense of provincial goals.

The providers, or at least the managers and the boards of most hospitals that I'm familiar with in this province, have been saddened to see over the years that we've waited too long for providing that kind of final authority that would make decisions and not let communities dangle in a Never-Never Land of not being able to reach consensus and do the things that everybody knows need to be done.

I think I can represent fairly the views of a lot of my colleagues and other people in the health care sector by saying that fundamentally people welcome this kind of legislation and the opportunity for the government to have a tool to impose change when it's not coming.

Mr Clement: Thank you. I respect your view on that. I just want you to clarify, if you could, in your methodology to improve Bill 26 you mentioned in the latter part of your recommendations safeguards with respect to the civil service, so that they respect the intent of the legislation. Can you give me some examples or elaborate on how you'd like to see that work?

Mr Ringius: We certainly know that there are entrenchments in organizations, in bureaucracies, in corporate, private and public, where the need is for direction from the minister to make it clear as to what is expected of the civil service, that there isn't the opportunity for the silos to say don't touch my area and look for areas not to make improvements and efficiencies. We need that communication. I think that takes a strong direction from the minister. I think we've had some experiences with that in some of the roadblocks that were happening in the Thunder Bay area and were not moving along because there isn't a clear understanding of governance models that were agreed to and then made changes to.

Mr Frank Miclash (Kenora): During your presentation, Dave, you talked about savings within the system and the reinvestment of these savings in non-existing services, and you mentioned recruitment of health care professionals, retention of those professionals in the north. I guess what I'm wondering is, what assurances do you have that those savings will remain here in Thunder Bay?

Mr Ringius: Previous communications with ministry officials under the hospital service review indicated that where savings were needed and there was not the delivery in the sector outside of the hospitals, they could be allocated until those services are filled, because you can't do all of the work inside the institutions, some of these services need to be put outside. So that's where the savings should go initially, and then any further savings would go obviously to deficit reduction.

Mrs Lyn McLeod (Fort William): I'll follow up. There's a whole host of areas in Bill 26 and even those aspects of Bill 26 that only affect hospitals that I'd like to ask you about. I'm not going to because I think we have an opportunity here to learn a little bit from the Thunder Bay experience, so I'm not going to get into issues like whether supervisors should be able to take over hospitals without any inspectors' reports, whether or not the Minister of Health should have the power to act unilaterally without regard to the Public Hospitals Act or any regulations under the act—I suspect you'd have some concerns about that—or whether the Minister of Health should have no liability at all for any decisions that are made, including funding decisions. I'm going to set those aside for now, because I want to pick upon the fact that, as Dave said at the very end of his presentation, we have a strong belief in this community about community resolution to problems, and we take some pride in our record of having been able to resolve issues locally and sometimes come up with creative solutions.

I have been pretty close to a full arrival at a voluntary resolution of a single amalgamated board, as you know, over a period of time. I guess one of the things that concerns me about this legislation as it applies to other communities and perhaps in the future even to our own,

because we have some unresolved issues, is at what point, at what time and in what way does the Minister of Health come in and have that involvement?

I think there is always need for a facilitating role in order to help a community arrive at decisions. But if a Minister of Health had come in—and, Dave, as you know, it took 10 years, a heck of a long time, to get to the voluntary agreement to bring about a single board. But if the Minister of Health coming out of Queen's Park had at any point in time come in and said, "Thou shalt do it this way," and the community wasn't convinced this was a good decision, I'm not sure that would have been well accepted in this community, just knowing what this community is like. I guess that's what's worrying me.

Maybe if we can build on the point Thunder Bay is at, and the experience we've had here, the question of how do we define community, how do we ensure that we've got community support—do you have some recommendations in that regard?

Mr Ringius: Certainly I've been involved for quite some time in the Thunder Bay experience through the chamber of commerce, which has looked for a single acute-care facility here. It was not until 1991 that we had some direction from a former Health minister, Frances Lankin, who had given some direction for that hospital services review. That review, in my mind, had a broad constituency from all stakeholders at that table and we had community input on a regular basis, continued to receive reports, and then sent the report in.

Even though it seems like 10 years, I think since that task force was established, we've accomplished a lot. There was not a whole lot of discussion around governance. It was fairly well accepted that there are basically two businesses in Thunder Bay: acute care and chronic. One of the areas that was not totally resolved was the mental health issue and that again was because of the way it's structured. We need to address that.

The time frame I think is much shorter now. I think we're in a more critical area. I think we've been around. Positions change, individuals change, jobs change, but I think overall the community is looking for the momentum to continue for Thunder Bay. It's been a good experience. All of the stakeholders are still there wanting to proceed. I believe we can accomplish our goals in a much shorter time frame than previously done in Thunder Bay.

Mrs McLeod: In part I think because there is an increasing recognition that the dollars aren't there, as you've noted in your brief—and I think everybody who's involved in providing health care understands that, and I think communities understand that, one of the reasons there's going to be a lot of concern about the exercise of decision-making power by the minister under this bill is that the powers are much more sweeping, because there is no clear requirement for the community involvement, there's no clear guidelines set out for that community involvement or community agreement to be sought.

There is also a driving force, as you've noted several times in your presentation, of balancing a budget, and in fact balancing a budget, as Mr Pouliot said, with some additional financial requirements the government needs to meet in its April budget. So you worry whether or not what's going to happen here is not guidelines and

facilitation from the Ministry of Health for community resolution of problems, but a minister who needs to drive a decision whether it's right or wrong for a community.

I guess it comes back to Frank's question. Unless there's some commitment of dollars to a community it will be very difficult for the Thunder Bay model, which has been achieved with a lot of sweat and a lot of hard work, to actually be carried through successfully, because you need the commitment of dollars. This can't be a way of saving money for the minister to balance the budget; it has to be a way of controlling the health care costs and keeping dollars in the community. I'm not sure whether you want to comment on that.

Mr Ringius: That's why we put in place here when consensus is not maintained—that's when we expect that there would be some, as you say, facilitator. The Thunder Bay experience worked well with a facilitator and we continue to use that method to resolve issues. Hopefully that will continue. If that can't happen within the time frames established by the community and the ministry, we need to step in.

The Chair: Thank you, gentlemen. Thank you, Ms McLeod. We appreciate your presentation this morning and your interest in our process. Have a good day.

0930

There are a few chairs still at the front—it's kind of a church setup here—for some of you folks standing at the back. I did neglect to say on behalf of the committee that we're delighted to have an opportunity to be in Thunder Bay. For some of us, it's our first trip, but it's great to be here. We didn't get much chance to look around last night, we didn't get in till 10 o'clock, but we are happy to be here.

Ms Lankin: Mr Chair, I almost got sidetracked by your little dialogue.

The Chair: I was hoping you would.

Ms Lankin: I know. I'd like to place a motion before the committee, please.

The Chair: Yes, Ms Lankin.

Ms Lankin: My motion is as follows:

Whereas there has been overwhelming public interest in Bill 26 and that 33 groups and individuals have requested to appear before the standing committee on general government today in Thunder Bay, which far exceeds the 10 spaces available today for hearings;

I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged for the community of Thunder Bay;

Further, that this committee recommends that the three House leaders meet as soon as possible to discuss this issue.

The Chair: As previously, I'd ask for unanimous consent to discuss that motion at our break at 12:30 rather than interfere with our presenters.

Mrs McLeod: I would like to acknowledge that as this motion comes forward repeatedly, we could solve a lot of the time problems if the government were to propose the motion and recognize that we have a lot of presenters,

including people in this room today, who are not being heard. It's one out of four or one out of three who's going to have an opportunity to be heard in Thunder Bay.

The Chair: We'll talk about that at 12:30.

ONTARIO HOSPITAL ASSOCIATION, REGION 1

The Chair: Our next group represents the Lake of the Woods District Hospital. Sue Straight is obviously not here. Bob Muir is the CEO and chair of the Lake of the Woods hospital, and Andrew Skene is the chair of OHA region 1 and the CEO of the Dryden hospital. Welcome, gentlemen. You have a half-hour of our time. Questions will begin with the government.

Mr Bob Muir: I'm Bob Muir, and not, as you've correctly pointed out, Sue Straight. I'm director of the Lake of the Woods hospital in Kenora, a little under 400 miles to the west of here. This year, fortunately or unfortunately, I'm also chair of the Ontario Hospital Association and co-chair of the JPPC. We've agreed that for this time slot—although I would like to answer questions as well—Andrew Skene, chair of region 1 of the OHA, which represents all of northern Ontario, will make our presentation.

Mr Andrew Skene: I would like to thank you, Mr Chair and committee members, for allowing me to present on behalf of OHA region 1 council to the committee concerning the recently introduced omnibus legislation, Bill 26. I'd also like to thank Bob Muir and Sue Straight from Kenora for allowing us to have this time slot to make this presentation.

Region 1 covers northern Ontario, and we go from Bracebridge, just north of Toronto, through to James Bay to the Manitoba border, so it's a fairly large area. The council takes a leadership role on matters of northern concern and regional consultations and advice and education for our members, and we've got about 48 hospitals in the region.

Bill 26, as you know, is a very complex package of legislative change and raises a number of concerns and questions for our hospitals in region 1. On December 18, the OHA made a presentation to this committee, supporting certain sections and not supporting other sections, and we're not going to go over what the OHA presented. The synopsis of what I will be doing today—you will be receiving a full brief, so I'm not going to read the whole brief.

During the process for the OHA submission, our region was involved and we held teleconferences to go through the OHA brief. For making this presentation, we had the region agree to one presentation, and the executive worked very closely together to make sure we brought a package for you.

We'd like to say that inequities exist in delivery of services in the north. Service gaps in the provision of health and social services general infrastructure have been well documented, and many studies are out at the moment—on the shelf—that can be looked at. We also note that first nations have their own distinct health care needs and requirements, and we must not lose these in any processes.

We believe that the policymakers and politicians need to understand and realize the northern problems of delivering health care before sweeping changes could be made.

Northern Ontario is 80% of the land mass and 9.2% of the population, so that leaves its own demographic problems. Often we don't have the critical mass to maintain full programs and not necessarily in all areas. In isolated areas, some programs can't be run and you rely on regional centres.

Statistics show that there are fewer social services and health care professionals in the north. Also, in terms of health status, we have a higher infant mortality rate, a higher morbidity rate and a higher motor vehicle accident mortality rate, which can be attributed to the roads and the distances of travelling.

The role of the hospitals in the north: Many were initially built by religious groups or private companies in the past who were committed to community development, and they continue to play a vital role in the community and in the economics of the community. The community hospitals are governed by volunteer trustees, and they have ensured accountability both to their communities and to the health care system to provide viable and affordable health care. We have some strong concerns over the application of Bill 26 that could lead to the undermining of the volunteer community trustee governance of our hospitals.

The hospitals in northern communities are sometimes the only 24-hour health care facility—and that's a very important thing—and they've become the sole provider of services within those communities. Significant downsizing of hospitals will have a proportionately much higher impact than those in the southern communities. Instead, maybe these organizational structures should be strengthened.

Various documents—Small Hospitals in Ontario: Towards the Year 2000—define some of the roles that hospitals can have in the health care setting in communities, and this works for northern and rural communities as a whole. Some of the traditional models of hospital care are not really carried out, because the hospital is not just a hospital, it has various other aspects—running ambulance services, mental health services—built on to the scale of economy.

The minister, in November at our annual meeting in Toronto, acknowledged that he needed an affordable and sustainable health care system, and that the government is going to focus on creating appropriate, accountable, integrated and cost-effective health care services.

We're supportive of changes in legislation, but it should be enabling to the northern remote hospitals. Horizontal integration, ie, mergers and amalgamations, may not be feasible in many communities, but a vertical integration of health care services within that community may be the way to go.

Most of you have probably heard of Access to Care in the North, a document derived by northern health care professionals that dealt with many aspects and came out in 1992. The process was based on the desire to be positive, innovative agents for effective change in the delivery of health care services for the northern region.

Since its release, it has received widespread support. We're pleased to see that some recognition to the north has come from that in the travel grant program, the delivery of the appropriate service or procedure happening in the nearest locations; that was tightening up the money being spent. And we have other areas, the underserved area program, moving to Sudbury, which was a good move. So we're getting the northern flavour.

We acknowledge the intent of the government to make available the appropriate tools to restructure health care, but these tools cannot replace the need for the development of strategy, and we would like to see a northern health care strategy, as we outlined in Access.

0940

We often assume that all communities have comparable health and social services infrastructures. This is not true. History has dictated. Guidelines for allocating resources to hospitals have to be relatively uniform throughout the province, essentially population-based. We know that in the north the population base is not always there, but we have to develop flexible guidelines in order to deliver health care.

Funding of the northern hospitals: We're pleased to see that there is a multi-year funding proposal before us now, and that's useful so we can see what's going to be happening in the future.

There have been some unprecedented funding reductions, and we can see the challenges to be faced in the future by the health care areas and other areas, but we trust that these allocations and reductions will not be applied across the board. We need an approach to ensure that there's fair allocation of resources among hospitals. We have to recognize that there are different circumstances faced by the northern, the rural. We have seen that the Ministry of Municipal Affairs is cutting less deeply in terms of some of its transfer payments to some of the northern communities, so there has been a recognition. We would recommend that there not be that across-the-board cut that would result in a substantial reduction and maybe elimination of total services and programs in certain communities.

We have to look at, with the major shifts of funding support from the institutional, that any changes out of that shift of funding from the institutional sector should be accompanied by clear plans and commitments to reinvest those savings in areas of crucial and urgent health care needs. We have to make sure there's a proper reallocation of funding. This is particularly necessary where the hospital is the sole provider of some health care services in the north.

Physician services: Shortage of medical human resources and the lack of viable coordinated medical service plans have been documented as major obstacles in the provision of adequate health services in northern Ontario. It might be from not having enough permanent physicians in a community to cover emergency services or not having enough specialists, whether they be general surgeons, psychiatrists etc. There have been many measures over the years, but we still have unrealized goals in fulfilling the medical needs.

The medical needs for physicians in communities vary from one community to another—they're not all cut from

the same cloth—and the standard, traditional physician-population ratios are not relevant, especially in the northern rural communities.

The recent incentive with respect to the approval of guaranteed minimum payment for physicians providing on-call services in low-volume departments is welcome, but other measures may be required in the long term.

There is the ability to manage very directly the supply and distribution of payments to a physician in Bill 26.

The ability to restrict billing numbers and privileges and place moratoriums: This will resolve a problem maybe in the short term, but will it resolve the long-term problem which we have to really look at? We have to look at the enhancement of recruitment and retention and advocate in order to prevent further migration of physicians from northern Ontario.

Limited options are presently available in the system for financial recognition of the greater breadth of responsibility physicians have in northern rural Ontario. Fee differentials may be required here. We look at what a physician has to do in a smaller community, and his skill level has to be far greater than that of a person at a walk-in clinic that has got a teaching hospital next door. We have to recognize that.

The third-year residency program is good and we need to see that enhanced even further, and that the people coming into the north have got the necessary skills.

We recognize that the government doesn't license physicians; that's the college's duty. However, when we cannot get people into the north, maybe we need to look at foreign graduates. Experience has shown that specialists and general practitioners who have graduated from other countries can make valuable contributions in the north, as they have in the past and as they are doing in other provinces now.

The Health Services Restructuring Commission under the Ministry of Health Act: Given that the members of the commission shall be appointed by the Lieutenant Governor in Council, region 1 council hospitals would like to see some provision made for representation from rural northern areas and small hospitals to be considered members of that commission so that the members of the commission will have a good understanding of the northern health care delivery system and be sensitive to the many issues that we have identified now and that have been identified in the past. Also, the council believes the commission's role should be to implement the plans either developed voluntarily by hospitals or developed by DHCs and approved by the minister. The minister, not the commission, should make the decisions relating to closures and amalgamations.

Region 1 agrees that effective mechanisms are needed to implement the structures. The Public Hospitals Act, section 6, provides the minister with new and sweeping powers. We understand that the minister, in his presentations to this standing committee on October 8, announced that he will be recommending sunseting the proposed Health Services Restructuring Commission. We agree with his recommendations but believe it is even more important that the sweeping powers vested in the minister under section 6 are also sunsetted.

In conclusion, I would like to reiterate that while region 1 council agrees with the government on the direction and scope of many aspects of Bill 26, there are areas that need further consideration, not to say changes. We are willing to work with the government and our partner agencies.

The Chair: Thank you, gentlemen. We've got about four minutes per party for questions, beginning with the government.

0950

Mrs Janet Ecker (Durham West): Thank you very much for coming forward today. I think one of the helpful things we've had over the last several days of hearings is that so many hospitals and representatives of the hospital community have come forward with what I think are some excellent suggestions for ways to continue the restructuring exercise and at the same time improve the way that we may be able to do that.

You make a very valid point about the difficulty if cuts are across the board, and I think our government has certainly recognized to date, with the way the municipal transfers were made, that there are unique needs in regions. That's an important point to make.

The second issue is that, again, you made the point about the importance of voluntary boards, the importance of community involvement in the restructuring process, which is something that Minister Wilson has stressed he believes in. He believes that the commission and the whole restructuring has to depend on that.

What I'd wonder is how we can ensure in the legislation that the principle of volunteer boards is being respected, because some provinces have chosen, frankly, to basically abolish hospital boards in their restructuring exercise, just sort of make everybody part of one regional board and things of that nature. We rejected that. We don't think that's appropriate, because we do believe the volunteer boards are important.

But at the same time there are also examples where, for whatever reason, the consensus that has been reached in some communities is that the restructuring exercise is not possible, that the board doesn't function or there are difficulties in the hospital, the quality of care or whatever, so that there was a need to somehow have authority for the ministry to act and in some cases, if quality of care is being threatened, to act quickly.

How do we balance that need to act in extreme circumstances with the importance of the volunteer boards and making sure that is there and that is respected and that the boards feel that is there and that is respected?

Mr Muir: I think part of the answer to that is to ensure, as we've said, that there are sunset clauses, not only for the commission but for other parts of the act as well that deal with the powers of the minister. We've also said, out of respect for voluntary boards, that, for example, hospitals that perhaps are in danger of being taken over should have the opportunity to at least put their case, to deal through the health councils and to use those mechanisms and to balance it. In the Public Hospitals Act at the moment there's a certain balance. The minister can act, the minister can do certain things; there are certain powers there that the minister has.

It is true that hospitals are also independent, and I know there was a concern about being able to deal with closure of hospitals. If that's the issue and if restructuring takes four years, I think there are ways, and we suggested ways, in which you can do that while at the same time recognizing voluntary governance, because if that doesn't happen, it will be voluntary governance in name only.

Mr Miclash: Thank you for the presentation. I agree with Mrs Ecker that we're certainly going to have to take a close look at the volunteer boards, especially in small northern Ontario hospitals. I know in both your communities they play a very important role in terms of fund-raising and ensuring the operations of both facilities. But I think something of greater importance is that we're often hearing about the cut in transfer dollars. I'm interested in hearing from the administrators of two very small hospitals as to what effect that will have on your operations in both Kenora and Dryden.

Mr Muir: Let me address that first. I represent a hospital which is an amalgamated hospital, 26 years ago, one of the first in Ontario. Those funds have obviously gone through the system already. I also represent a hospital which serves—35% of its patients are first nations. In most of those communities primary care systems are rudimentary.

I know the funding formula. I've supported it in the work I've done. But I also know where the formula ends and policy begins. I know that the northern factor was taken out of the formula. I know that we can't come up with criteria around socioeconomic conditions, which everybody recognizes is a problem in some northern areas and certainly adds to the cost of providing care. We can't do that; it's not currently recognized in the formula.

I should also say that outside the city of Thunder Bay there's one resident pathologist, one resident radiologist, two resident internists—I hope I'm correct on that—three resident psychiatrists. In our area there are three general surgeons, two of whom are in Kenora. I began the conversation by saying I live 400 miles west of here. All of the specialists I talked about—and that's pretty thin gruel in any area of the province—are in Kenora.

The issue for us, when we look at the provision of care to first nations people, the type of work we do, the way in which we're funded, the fact that the formula doesn't include these other things—and I'm not criticizing the government for that; I'm saying it's a fact—I think if there isn't special recognition, the underpinnings of the thin secondary care system that we have outside Thunder Bay are going to be severely damaged.

I'm not going to talk about things I know about in some other areas, but if they're talking about a range to even 5% for some of these hospitals, it simply undermines the basic level of service that can be provided in those areas. We've made some suggestions to the government. I think, certainly from people I've spoken with, there's an understanding of that, but the size of the mission is so great that obviously, in some areas of the province, cuts of the magnitude of even 5% are going to have to be dealt with in terms of public policy and not the funding formula.

Mr Skene: To go on with what Mr Miclash asked, to Dryden 5% would be nearly half a million dollars. That

is over twice what we had to take out in the social contract. That was after we had to kick in an extra \$100,000 for pensions, the employer health tax and things over the last few years. Therefore, we would have to be looking at serious program cuts, and that would happen with many of the northern hospitals.

Ms Lankin: I'd actually like to make a couple of comments on some of the things I've heard. I don't have a specific question. I think you've been very clear in your recommendations about what areas of the legislation you think should be amended.

One of the things that has interested me—and Bob, I think your comments were a bit different—over the course of the hearings so far is the hospitals that have said, "We think the minister needs these extraordinary powers essentially to force us to restructure." Yesterday it was interesting in Sudbury. We heard two different presentations from the same hospital corporation talking about how in that community there had been a real problem with people moving ahead and getting the job done, and in fact it took the minister five times to tell the DHC to get the sole governance issue off the table, and therefore the government minister really needed this legislation.

They couldn't tell me how a restructuring commission was going to solve the problem that had been there and they didn't tell the committee that the previous minister had given a very clear direction that the governance issue was on the table and that the lobbying they'd referred to was, in some part, their own lobbying of government to change the consensus that had been arrived at through the DHC.

I think that while we hear from a lot of hospitals that hospital CEOs and boards are ready to move on with this and ready to get these things done, it really is a perspective. If it's not your hospital that's being touched, then perhaps you're in support of it; if you get the decision changed by the minister, the new minister, or whatever, then maybe you're in support of it.

What I have a problem with is understanding how the hospital commission, with no terms of reference and no mandate and no linkage to the local DHC and local restructuring planning that's been going on, is ever going to solve that. In the end, it comes down to a minister's decision, the minister is accountable, and I don't see how the legislation is going to provide anything more than the power the minister already has to step in and to facilitate when communities need that and request that.

Mr Muir: I'm not sure if that was a question, but I think the OHA presentation has said that while we support the idea of a commission—in fact we had some conversations with the ministry—the fact is that we haven't seen the terms of reference. We are interested in the linkage between the commission, the health council and the boards which are going through restructuring. At the end of the day, though, you cannot come up with \$1.3 billion in this province in cuts over three years unless you close some hospitals, you amalgamate hospitals, you restructure, and the government has said that. In order to do that in three years, you need a mechanism other than the process we have now.

The OHA is on record in saying that we support that, but with conditions. But we are also saying that we want to see the terms of reference. We are also saying that at the end of the day, both as citizens of this province and, obviously, as a lobby group, we would like the minister to make the final decision. We think it's important that the minister closes hospitals. We think it's important that the minister, on behalf of the people of Ontario, through the process that we respect, does those things, and not some commission that would have these extraordinary powers.

Ms Lankin: Just so you know, we'll be seeking some amendments from the government to try and achieve those terms of reference in the legislation.

The Chair: Thank you, gentlemen. We appreciate your presentation this morning.

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OGDEN-EAST END COMMUNITY HEALTH CENTRE

The Chair: Our next group is the Ogden-East End Community Health Centre, represented by Joe Devlin, the executive director. Good morning, Mr Devlin, and welcome to our committee. You have a half-hour to use as you see fit. Questions would begin with the Liberals if you leave time for questions. The floor is yours.

Mr Joe Devlin: My name is Joe Devlin and I am the executive director of the Ogden-East End Community Health Centre, or as we like to call it, a CHC. Our CHC serves two neighbourhoods in Thunder Bay: Ogden and the East End. The total size of our catchment area is about 10,000 people and includes many of those who need health care the most: seniors, natives, low-income families and the homeless.

Our CHC began offering programs and services in June 1992. Today, we serve over 2,000 clients, and the demand for our services is continuing to grow at the rate of 60 new clients per month. We employ a range of health care professionals to meet the needs of our community, including a family physician, nurse practitioner, registered nurse, registered midwife, health promoter, outreach worker, counsellor, registered dietician and chiropractist. All our staff, including the physician, are on salary. We maintain our accountability to the community we serve through our community board of directors elected annually by the Ogden-East End community membership.

The Ogden-East End Community Health Centre is one of over 50 CHCs in the province of Ontario. While each CHC is unique, we all share a commitment to the fundamental principles of providing accessible, comprehensive primary health services with an emphasis on health promotion and empowerment.

We believe that the government also supports these principles because we find them articulated within the Progressive Conservative Party's document called The Mike Harris Forum on Bringing Common Sense to Health Care, which was released on December 2, 1994.

For this reason, we urge the government to ensure that the goals and commitments outlined in the Bringing Common Sense to Health Care document are incorporated

into Bill 26. Allow me to give you some examples of what we think this means:

A commitment to public involvement: In the Common Sense Revolution, it was stated that:

"We are ready to listen, to learn and to work with anyone who wants to join us and who can show us more creative, more effective ways to end waste and duplication.

"Our commitment is carved in stone—a 20% cut in non-priority spending in three years. But how we get there will be discussed in partnership with all Ontarians."

As a community health centre, we are also committed to working in partnership with others to create positive changes in the health care system. We are very concerned, however, that the size and complexity of Bill 26 and the speed with which the government is moving to introduce this into legislation does not allow for adequate public involvement. If the government is still committed to working in partnership with all Ontarians, then we would request that you do the following:

(a) Break up Bill 26 into reasonably sized, coherent packages of legislation which can then be properly assessed by those Ontarians affected.

(b) Allow more time for public hearings in order that the many groups which have expressed a keen desire to speak to the issues in this bill will have a chance to be heard by the government.

A commitment to universal and equitable access to health care: The recent reduction in social assistance has had a major impact on many members of the Ogden-East End community. Already some people are unable to cover the costs of the basic prerequisites of health, such as food, clothing and shelter. Bill 26 heightens this inequity. The imposition of copayments will have a greater impact on social assistance recipients and low-income seniors. The deregulation of drug prices and the imposition of a wider range of facility fees are all going to increase the hardship on our low-income populations. These sectors already bear an enormous burden due to the battle against the deficit.

The imposition of user fees in the past has not been successful in lowering costs and reducing the overall utilization of the health care system. What it has been successful at is reducing accessibility for low-income groups. Saskatchewan provides a good example of this. That province tried charging user fees for physician and hospital services during the period between 1968 and 1971. What that experience showed is that when user fees were in place, utilization of physician services by the elderly and the poor decreased by almost 18%, but overall physician and hospital costs remained virtually unchanged. That's from an Ontario Council of Health report in 1979.

For these reasons, we regret the implementation of user fees into a health care system that is based on the principle of universal access. We also note that you said, "Under the Common Sense Revolution plan, there will be no new user fees." We would urge the government to maintain its commitment to not introduce new user fees, and therefore to remove those sections of Bill 26.

The specific sections we refer to are the imposition of copayments in schedule G, part I, the deregulation of drug prices in schedule G, parts I and II, and the imposition of a wider range of facility fees in schedule F, part IV.

A commitment to the individual's right to privacy: Bill 26 contains provisions that would allow the government to gain and use personal information in an unprecedented manner. Clause 6(2)(d) of the Ministry of Health Act currently provides the minister with the power to "collect such information and statistics respecting the state of health of the public, health resources, facilities and services and any other matters relating to the health needs or conditions affecting the public as are necessary or advisable, and publish any information so collected."

Bill 26 proposes to further extend these broad powers to provide the government with the authority to disclose personal information to any party it enters into an agreement with.

The highly confidential nature of health records requires handling with the utmost care. While the information medium, be it paper, electronic or whatever, may be owned by the respective health provider or facility, the actual personal health information belongs to persons referred to in the respective health records.

The Progressive Conservative Party's commitment to a health care bill of rights identifies, among other rights, the "right to participate in decision-making regarding one's own health and the right to treatment free of discrimination and which recognizes one's privacy, dignity and individuality." We are concerned that, unless amended, the relevant Bill 26 provisions will put at great risk the privacy, dignity and individuality of Ontarians.

Our recommendation is that you ensure that Bill 26 adequately provides for the protection of patient-client confidentiality.

A commitment to fostering community involvement: In Ontario local public hospital boards of directors are incorporated under the Corporations Act. In addition, specific corporate powers are provided under certain sections of the Public Hospitals Act. This approach ensures that a local facility or agency is subject to appropriate lawful checks and balances contained in the respective legislation.

At the same time, this approach allows community input and local autonomy and authority in decision-making. Bill 26's provisions to amend various portions of the Public Hospitals Act have the direct effect of undermining and nullifying a local board's authority and autonomy. In concert with other provisions of Bill 26, these amendments eliminate the capacity of local boards to ensure that communities have a say in establishing their health priorities.

In addition to giving the Minister of Health the power to make decisions on hospital amalgamation and closure without community consultation, these amendments render local community boards of directors instruments of the minister. Through the appointment of a hospital supervisor, the minister can assume all the rights and authorities of a local community hospital board of directors. This means that, effectively, the minister has the power and the authority to manage the health care system at the local level without community input.

In Bringing Common Sense to Health Care, you said that your goal was "to give communities more say in establishing their local health care priorities, as well as how and where they want health care services to be provided."

You further stated that: "We believe the public should be a key player in determining local community health care priorities. By enabling communities to determine their health care priorities, we acknowledge the need for flexibility in the local health care mix."

It would appear to us that Bill 26 will need to be amended to ensure consistency with your earlier statements regarding the pivotal role of the community in local decision-making.

Our recommendation is that you add provisions to Bill 26 which allow for public consultation before major decisions are made.

A commitment to bringing common sense to health care: As you can see from what we have said, we believe that Bill 26 needs to affirm a basic set of goals and principles for positive health care reform. We see many such goals and commitments articulated in the Progressive Conservative Party's document called The Mike Harris Forum for Bringing Common Sense to Health Care, which was released on December 2, 1994.

Our recommendation is that you ensure that the goals and commitments outlined in the Bringing Common Sense to Health Care document are incorporated into Bill 26.

On behalf of the Ogden-East End Community Health Centre, I would like to thank you for this opportunity to address some of the health issues arising out of Bill 26. I trust you will see our comments as constructive.

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The Chair: Thank you for your presentation. We've got about six minutes per party left for questions, beginning with the Liberals.

Mrs McLeod: I appreciate the fact that you've touched on a broad number of the issues that are of concern in Bill 26 and that you've also reminded the current government of some of their past commitments. I thought you missed one, though, which was the commitment that we thought was pretty clear about no cuts to health care, and what this bill is all about at the bottom line is finding \$1.5 billion in the health care system for deficit management. So that creates a part of the problem.

One of the areas, of course, in which they looked to find some dollars is in the copayments, which you've addressed quite clearly. By the way, I think all of us on this side of the table completely agree that this bill should be broken up so that we're not jumping from the powers of the minister to close hospitals to the issue of copayments to deregulation of drugs and what that's going to do to pricing to billing numbers for a physician and whether that's going to drive more physicians out of northern Ontario.

On the issue of copayments particularly, and knowing that you work with a large senior population at Ogden-East End, one of the things we've been hearing from pharmacists is that there is a particular problem for senior populations if you prescribe large volumes in your prescription; that it's better to break it into more frequent prescriptions of smaller volumes, that seniors can manage that better, and there's actually less wastage of the drug and less cost; that if you bring in a copayment, seniors are likely to be, in order to try and save them the cost of that copayment repeatedly, given larger and larger quantities of their prescription at one time.

I just wonder if you'd comment particularly on your concerns with the senior population about this impact of copayments.

Mr Devlin: I think that's just one example of a broader issue of where economic goals and health goals may not be in sync, and that is an example of one of the impacts that this bill will have if it's not amended. You'll see situations like that where people will try to save money because they have other things they have to try to spend their money on, some of their basic needs, and that will have a detrimental impact on their health in some cases.

Mrs McLeod: Do you think it will actually force people into choices?

Mr Devlin: And sometimes poor choices in terms of their health.

Mrs McLeod: On page 3 of your brief you make very passing reference to the imposition of a wider range of facilities fees. You've obviously taken time to read Bill 26 and the health care provisions. Would you like to expand on that? This is one of the issues that doesn't come up very often in our presentations, that this bill does open up the possibility for hospitals, for example, by regulation, to charge fees for services they don't now charge for.

Mr Devlin: I wish I could speak in more detail about that, but I have to be honest. The speed at which we had to react to this didn't really allow me to do my full homework and get a full set of footnotes for every piece. I found the legislation rather mind-boggling. When we looked at it, we could see some of those references, but I don't have them at hand.

Mr Michael Gravelle (Port Arthur): You're not alone, Joe, in finding it mind-boggling. Thank you very much for your presentation. I want to pick up on your comments about the individual's right to privacy. Obviously, great concerns have been expressed since the bill came out, the concept that indeed people's personal health records can be made public and used in a manner that obviously would be a tremendous infringement. Can you give me your take on what the implications are if that aspect of the bill is not amended?

Mr Devlin: One of the biggest impacts is somewhat hard to document, and that's the undermining of the trust between the recipient of care and the provider of care. We rely very strongly on a bond of trust. That's sacrosanct, the doctor-patient confidentiality. This has the potential to undermine that. It means that information can be released to other agencies, it can be released to the police, it can be released to other bodies. I think people might be reluctant, in some cases, to be forthcoming with information that's very important for those making decisions about what they need in terms of their health care.

Mr Gravelle: Something you didn't necessarily refer to directly but that I'm interested in, in terms of the impact of this bill on the people who use your services, is the community response to this, the awareness of the bill itself and some of its implications. Have you had people coming to you expressing concerns about the scope of the bill, that it is mind-boggling, as you put it, in terms of the people you provide services to?

Mr Devlin: We haven't had a strong reaction to the bill, and that's probably due to a couple of things. One is that a lot of the people we try to place an emphasis on serving are the marginalized, the disempowered. They feel they've been screwed by the system for a long time so they don't feel they ever have a chance to make a statement, or that it will make any difference. People tend to just try to survive as best they can. As I said earlier, many of them have now experienced social assistance cuts. They're just struggling to make ends meet. Finding the time to get hold of a bill and read through a lot of legal mumbo-jumbo is not on their priority list.

Mr Pouliot: A comment, perhaps, and a couple of questions in this six minutes allocated to our party. You represent the human dimension, in my opinion what is best about people.

We'll call him Harry Smith, though it could be Ms Jones. Harry comes to see you, Joe, and he's one of the marginalized; he's not very rich. He wishes to be like the others. Harry needs care. You mentioned at the beginning that the client group of people who seek that essential service is growing. You anticipate that the money available to provide that service, to tell Harry he's going to be okay, that he too is taken care of—well, you'll have more Harrys and less money.

I have a \$5 bill here. With the highest of respect to Harry, would Harry understand the complexities of this side of the \$5 bill being a user fee, and this side here being a copayment? If Harry used a service last week and it didn't cost him anything, and he uses the service next week and it's costing him his last \$5, to him he's a user of the service. He shall pay, and he shall pay big-time, I can assure you.

Let's make no mistake about this. In terms of consultation, these people were dragged into this thing, screaming and kicking until the last second. That's why we're here. The compliment of your visit is not because of the house of benevolence, and I want to make this very clear.

You will get less money. There has been some rumour that the money saved will be rededicated, put back into the system. We don't know when, we don't know whom. Have you been consulted? Do you have the ability and the desire? What does your gut feeling tell you? Will you be consulted to make sure the money is dedicated so that the Harry Smiths of this world, the growing number of Harry Smiths, will have their rightful place under the sun? First tell me about user fees—take his last \$5—and then tell me about consultation in the future.

Mr Devlin: To quote an earlier person, I'm not sure if that was a question or not. A couple of comments in response to what you've said, and one is about user fees. That's not the only barrier that many people in our community face. I mentioned that we serve a homeless population. That they may not even be in possession of a health card, though they're fully entitled to have one, can be a barrier to access for many services. It's not for us; we don't require that somebody have a health card to receive services. We're very much dedicated to trying to overcome whatever barriers exist for people in receiving the health care that's a right of every Canadian to have, so any time something's proposed which is going to be a barrier, we have a concern about it.

In terms of your comment that there will be cuts, that's why we are trying to emphasize to the government that we would like to see its position paper Bringing Common Sense to Health Care incorporated into Bill 26. They made a number of goals and commitments in that which we found very reassuring; we found much in there that we could identify with. But if that's not incorporated into Bill 26 our fear is that the overwhelming preoccupation with the deficit will overwhelm any other consideration.

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Ms Lankin: One of the things I have been concerned about in the legislation is that the powers of the restructuring commission, for example, aren't linked in any way to local community consultation. The government actually has said in these hearings that it is the intent, but I would like to see that linkage in the legislation.

The other thing is the reinvestment of these dollars saved by hospital restructuring into the community. While again they say that's their goal, in communities like Windsor, with the restructuring proposals ready to implement there, they've actually taken the operating savings away and have said, "No, you can't have that to reinvest in the community."

If you have comments about those two areas and what it would mean in terms of gaps in services at the community level if we don't have that reinvestment, it would be helpful. I think the government needs to hear that.

Mr Devlin: Once again I would say that we would like to see their position in the document incorporated into Bill 26, because they do talk about reinvesting the savings within health care.

But I'd like to step back and say that sometimes we make the mistake of saying that health is health care, that health is doctors and hospitals. It's not. It's a broad set of things, and already we're seeing the impact of government actions. We try to work in partnership with many other organizations. Quite a number of those are funded through social services, and they've experienced cuts, so our ability to work in partnership with other groups in the community to maintain and improve the health of our community has already been jeopardized.

If there are going to be savings through hospital restructuring, we need to look at how best to reinvest that. It may not be the case, necessarily, that reinvesting it in capital projects is the best way. It may be that basic things, shelters for women and things like that, are what's really needed.

Mrs Helen Johns (Huron): Thank you very much, Mr Devlin, for your presentation today. I appreciate all the time you've put into it. I just have to clear up a couple of things before I ask some questions, if you don't mind.

This government made a commitment that we would maintain \$17.4 billion in health care, and we will do that over the time we are in power. The commitment we didn't make was that we would maintain the status quo in health care. We have to make some changes to make the system a better system so that the money is utilized better by the consumer—the end user—and by the community. We're doing some of those things in this bill to try to manage the system and to try to better get money down to the end user, we believe.

I can in some ways prove this in the fact that people are coming out of hospitals much sicker and quicker, as we've closed 6,700 beds in the system, but we've closed no hospitals at all; that's the equivalent of 30 medium-sized hospitals. At the same time, long-term care, especially in the north, is growing by at least 13% per year and we haven't been able to give it the money it needs to be able to grow.

We will have heard, by the time this committee is over, from about 750 different people throughout Ontario, so we believe we're hearing from a number of people about what we should be listening to, what they like about the bill, the things they're having problems with. We think we are listening and we are hearing what people have to say.

In terms of the drugs, I want to comment that with the copayment we have put in, we intend to have 140,000 working-class people able to get on the Trillium drug plan that they have never been able to have before. I think that having health care for 140,000 working people in Ontario is an important aspect.

You talked about consumer and community involvement. We haven't touched the process whereby the district health council looks at the planning, decides what the community needs are for health care in the community. Is that not the good community involvement that you would like to see maintained?

Mr Devlin: One thing that's not clear to us is what the relationship would be between the hospital restructuring commission that you're proposing and district health councils. It would help to have that clarified.

Mrs Johns: As long as the district health council is involved in the planning process of what happens in the community, that's basically what you were looking for in section 5.

Mr Devlin: If we understand the bill—and I'm not sure that all of us do completely understand it—it's proposing that the minister could, with pretty broad discretion, step in at any point and pretty much do anything the minister so chooses in terms of that restructuring. That, I think, can undermine any process of community consultation. When you consult with people, they're looking at you to say, "Are you really interested in what we have to say and are we really going to have an impact on what's going to happen, or are you just going through the motions?" That's what we find in our own work, that our credibility with people in terms of our intentions is very important. What we've been trying to say this morning is that that's just not clear enough in the bill.

Mr Clement: Mr Devlin, I take it from your discussion about the disclosure of confidential information that you don't like a bill or an act that says that the minister may enter into agreements to collect, use or disclose personal information relating to eligibility. Is that the major concern you have?

Mr Devlin: One of them, yes.

Mr Clement: I hate to be disingenuous and I don't want to put you on the spot, but I just read from the old act. That power was there in the old act. What the new act does is say that the minister must use that information "for the effective management of the health care system

and the delivery of health care services." What's so scary about that?

Mr Devlin: I'd have to say that we're not the only ones who are concerned about that. The privacy commissioner, a whole range of people, have said—

Mr Clement: I just read you the act, though, sir.

Mr Devlin: It's not just in that portion. There must be about a dozen places in Bill 26 that talk about additional powers for the minister to collect the information. All we're recommending is just ensure that Bill 26 provides provisions for the protection of confidentiality.

Mr Clement: I just want it on the record that there were provisions in the old act that relate to disclosure, what the minister can and can't do, and in some cases the new act is more specific than the old act.

Mr Devlin: I actually had the chance to watch the current Minister of Health on TV Ontario speak to that very point and he seemed to give a very coherent, intelligent answer to it. All we're saying is please make that clear in the bill. If that is the case, please make it clear in the bill, because it's not.

The Chair: Thank you, Mr Devlin. We appreciate your presentation here this morning and your involvement in our process. Have a good day.

Mrs Ecker: Mr Chair, I just want a clarification from Ms Lankin. I wasn't sure if I understood when you were talking about the savings from some of the areas not being allowed to go back in. My understanding is that those savings are going back into being reinvested in programs where there's a priority, like cardiac, paramedic, kidney dialysis.

Ms Lankin: Mr Chair, is this in order? I would love to enter into a debate with Ms Ecker. You know I've been dying to have this opportunity. If she's opening up the door, this is the moment for it. I'm ready.

The Chair: We got into this particular situation yesterday and I would just as soon we not do it today. We are here to listen to the people of Thunder Bay and district make their presentations to us, not to argue with one another.

Mr Pouliot: We're being provoked.

Mrs Ecker: I wasn't arguing. I asked for a clarification.

The Chair: If we could leave it at that, I think the people in the room would appreciate it.

Ms Lankin: If you would allow your parliamentary assistant to the Minister of Health to answer the questions I've tried to put on the record on a number of occasions, we could have a very constructive debate, Ms Ecker.

The Chair: Thank you, Ms Lankin.

THUNDER BAY AND DISTRICT LABOUR COUNCIL

The Chair: The Thunder Bay and District Labour Council is represented by Richard Armstrong, the second vice-president and member of the health committee, and if the lady would introduce herself, we'd appreciate it. Welcome to our committee. You have a half-hour to use. Questions would begin with the New Democrats. The floor is yours.

Ms Judy Monteith-Farrell: I'm Judy Monteith-Farrell, a delegate to the district labour council.

Mr Richard Armstrong: On behalf of our affiliated members, the Thunder Bay and District Labour Council welcomes the opportunity to present our concerns over Bill 26, the Savings and Restructuring Act, 1995.

At the same time, we express at the outset our disdain and opposition to the undemocratic manner in which the Mike Harris government attempted to sneak Bill 26 into the Legislature on November 27, 1995, while the opposition and the media were preoccupied with the economic statement. It is clear that the government's intention was to ram the bill through before Christmas and make it law, a bill that would impose the most sweeping, fundamental, irreversible changes in the history of Ontario, and without any public debate. We now have public hearings, but the government intends to pass this draconian bill by the end of January 1996.

The passing of the bill is undemocratic. No one, including members of the public, the media, the opposition parties, perhaps even the government itself, has had an adequate opportunity to study the bill or adequately speak together as a community about the changes it brings to our fundamental social values or the democratic process for decision-making within our society. Every day, new information is discovered on how this bill will affect our lives. The Minister of Health and the Minister of Municipal Affairs and Housing are unable to explain the meaning of very important sections of the bill for which their ministries are directly responsible.

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It is clear that the direction of the bill will move Ontario towards an American style of government which is based on the hedonistic individual and the free market. This will not build a healthy society. It will destroy the distinctive Canadian society which we have experienced over the years.

Every union, every worker, every disabled person, every senior citizen and every child will come to learn how this bill hurts them. As their frustration grows to anger and rage, the government will experience protests and strikes as never before, a reaction that will equal the extreme action of the bill. This bill will destroy local democratic institutions, devastate public services and impose hardships on all but the richest Ontarians. It is especially hard on those who are most disadvantaged. Bill 26 is nothing short of a naked grab of power by an extremely authoritarian, autocratic and undemocratic government.

The bill creates three new acts—the Public Sector Salary Disclosure Act, 1995; the Ontario Loan Act, 1995; and the Physician Services Delivery Management Act, 1995—it totally repeals two acts—the Public Halls Act and the Bread Sales Act—and it amends a total of 44 other acts.

Given the massive nature of this bill, there should have been a process which provided more time to review the full document. Given the significance, the process should allow for the democratic input of all concerned, not the limited few of us who are fortunate enough to have slots at these hearings.

As an overview, some of the substantial changes to the bill include:

- The rollback of pay equity for women.

- The deregulation of drug prices and the introduction of user fees for the drug benefit plan.

- The enormous power to the Minister of Municipal Affairs to unilaterally restructure, amalgamate and dissolve municipalities.

- The gutting of laws governing cleanups when mines are closed.

- The increased power of the cabinet and the Minister of Health over hospitals and doctors. Under this bill, the Minister of Health will be able to close hospitals, appoint a supervisor to take over hospitals and tell individual hospitals which services they can or cannot provide.

- The repeal of existing laws giving preference to Canadian-owned, non-profit health care providers and the removal of a public tendering process. It ensures that the door is open to the American for-profit companies to set up clinics.

- The opening of the door to new user fees for a wide range of health care services, including hospital services.

- The rewriting of rules for bargaining with hospital workers and others within the broader public sector, including police officers and firefighters, forcing them to consider the possibility of service cuts when they decide wage levels.

- The limiting of access to government documents and increases in fees under the freedom of information act.

- The sweeping immunity of government at all levels from legal challenges.

- The absence of any appeal process for health care providers or citizens.

No sector is as significantly affected by Bill 26 as the health sector. Bill 26 will impact on the quality of care. It will encourage privatization of health care. It will direct attacks on the elderly, the poor and all those who need quality care. The primary objective of health care should not be profit; it should be quality of care. The bill will permit and even encourage extra-billing and entrench two-tiered medicine. It in fact violates the Canada Health Act.

Bill 26 will put our health care system in a critical condition by granting omniscient powers to the Minister of Health over hospitals, physicians and patients' confidential records; by repealing provisions that give preference to Canadian-owned, non-profit health care; by deregulating drug prices, introducing copayments and deductibles for prescription drugs and opening the door to user fees for all kinds of health care services. The only winners in this bill are the US health care firms and multinational drug firms.

The balance of this document will provide a more detailed analysis of the schedules that affect health. It is our hope that you will have a better understanding of our concerns about the impact of this bill.

Ms Monteith-Farrell: Schedule A, the Public Sector Salary Disclosure Act, 1995: This is a new law requiring public sector employers to make public a list of all employees who earn \$100,000 or more, including position, salary and benefits. It applies to the Ontario public service, municipalities, universities, boards of education, Ontario Hydro and basically everything considered broader public sector. It includes non-profit employers receiving \$1 million or 10% of gross revenues from the

Ontario government, with one exception: It does not apply to for-profit enterprises; for example, for-profit nursing homes. This initiative was announced by Ernie Eves on November 23, 1995.

Schedule F: Our review of this schedule leads us to the conclusion that this is a direct attack on the principles of the Canada Health Act. It has the arbitrary power to close public hospitals and/or to invite private American or other profit-making corporations to open licensed fee-charging facilities in Ontario. It also permits user fees, extra-billing and firmly establishes a two-tiered medical system.

Schedule F amends the Ministry of Health Act, the Public Hospitals Act, the Private Hospitals Act and the Independent Health Facilities Act.

Amendments to the Ministry of Health Act. Facts: Bill 26 establishes the Hospital Services Restructuring Commission whose mandate is to implement the government's agenda on hospital restructuring. The commission is totally protected from any liability in implementing hospital restructuring, and section 8 of the Ministry of Health Act deletes any references to the district health councils. Bill 26 repeals section 8 of the Ministry of Health Act.

The changes to the Ministry of Health Act create a new Health Services Restructuring Commission, which one suspects is designed to provide a vehicle to cover for the government on unpopular decisions like hospital closures. The new section does not mention district health councils. Health councils should be strengthened to provide greater community input.

The proposed changes to the Ministry of Health Act make it clear that the needs of the people of Ontario are secondary to the needs of the government. The Minister of Health is not as concerned with supporting and assisting communities as he is with devising and legislating ways to force this government's solutions on to communities without regard for the consequences.

Mr Armstrong: In fact, Bill 26 says the Minister of Health can make "any direction related to a hospital" that he wants to as long as he considers it to be "in the public interest to do so." According to this bill, the public interest is defined as what is in the interest of the Minister of Health.

Public interest is used throughout schedule F. The definition of "public interest" is added to the Public Hospitals Act in section 9.1. The clause states that the minister and cabinet are not limited by these matters and can consider "any matter they regard as relevant." The list includes (a) the quality of the management and administration of hospitals; (b) the quality of the care and treatment of patients in hospitals (c) the proper management of the health care system in general; and (d) the availability of financial resources for the management of the health care system and for the delivery of the health care system.

The availability of resources is entirely a matter of priority. The Minister of Health may well find fewer resources available for health care because more is needed to cut the income tax of the well-to-do.

Bill 26 changes the fundamental relationship between the public hospitals and the government. The minister and his cabinet can override and/or replace the independent

decision-making of hospital boards and the community the board members represent. The act grants the minister the power to virtually dictate any aspect of the operation of public hospitals.

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Under Bill 26, a supervisor can be imposed at the Lieutenant Governor in Council's discretion, with no connection to an investigation. The supervisor has the power to take over a hospital, to exercise all powers of the board or corporation. In fact, the supervisor has any and all powers the government specifies. The supervisor is dispatched by the government, reports to the minister, responds to the directions from the minister and carries out "every direction of the minister."

The protection for the supervisors and investigators from personal liability is further extended to anyone assigned ministerial power. That means that the bolstering commission set up by the minister, acting on behalf of the minister, can order a hospital to cease operating or stop providing service with immunity.

Amendments to the Private Hospitals Act. Facts: The minister has the power to close or terminate any grant of any private hospitals without notice. Hearings or rights of appeal will be repealed. The minister is protected from liability.

In schedule F, the minister amends the Private Hospitals Act to give the minister the power to revoke a private hospital licence at any time and to reduce or terminate any grant, loan or other financial assistance without notice where the minister considers it in the public interest.

No hearings or rights of appeal presently provided under the Private Hospitals Act would apply. Again, the minister is immunized from any legal liability as a result of the closure or funding decisions according to the bill.

Ms Monteith-Farrell: Amendments to the Independent Health Facilities Act. Facts: Bill 26 expands the definition of independent health facilities to include any facility or service that the minister defines through regulation. It allows for the expansion of independent facilities licensed to charge a facility fee over and above what they receive from the government for insured services—this is called extra-billing. It repeals all preference to non-profit or Canadian operators, thus opening the door to private American or profit-making corporations to open licensed, fee-charging facilities in Ontario. It removes the requirement for public tenders and allows the minister to send a request for a proposal to one or more specified persons.

In the Independent Health Facilities Act, it becomes evident that the government is trying to facilitate the privatization of health care. The bill gives the minister broad new powers to designate new services and facilities to be covered by the act.

The omnibus bill proposes changes to sections of this act which are crucial to our maintaining a universal, accessible, not-for-profit, publicly administered health care system in Ontario. In Bill 26, the terms "facility fees" and "independent health facility" are redefined to allow for a charge or fee to be made for any service designated by the minister and includes any facility the minister defines through regulations. Independent health facilities can be expanded far beyond their present use in

the system and will be permitted to charge fees to insured persons. This, again, is called extra-billing.

The definitions of "health care" and "health record" are repealed in subsections 3(2) and (3). "Insured service" is changed to just "service." This allows for deinsuring services and implementing user fees in other parts of Bill 26.

The bill repeals existing subsection 6(3), preference for non-profit facilities and for Canadian ownership. This is an obscure section worth emphasizing. If the government's intention is not to encourage American for-profit companies to take over more of Ontario's health care, then what is its intention?

Schedule G amends the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act, 1991. Facts:

Bill 26 introduces copayments and deductibles for seniors and social assistance recipients. Cabinet has the power to increase these user fees at any time.

It also deregulates prescription drug prices. Ontario will be the only province that does not regulate drug prices.

It repeals the process to negotiate dispensing fees between the government and the Ontario Pharmacists' Association.

The minister also unilaterally determines which drugs will be listed and delisted in the formulary.

The minister has the power to overrule the decision of a doctor or pharmacist as to what is appropriate medication by refusing to pay and by requiring the patient to bear the full difference in the cost between the approved drug and the prescribed drug.

As advertised, this introduces copayments and deductibles for seniors and social assistance recipients. It also deregulates drug prices. The new name of the act is the Drug Interchangeability and Dispensing Fee Act, since it no longer regulates costs.

Mr Armstrong: Ontario will become the only province that does not regulate drug prices. The government will say deregulated drug prices will go down, but there's no reason anyone should believe this; or perhaps Ontarians with health problems will be expected to haggle over prices with pharmacists, as they have to do with grocers for their tuna.

All recipients of the Ontario drug benefit plan will now pay a minimum \$2 charge per prescription. In addition, where an individual's income exceeds \$16,000 or family income exceeds \$25,000, a \$100-per-person deductible per year will be instituted. Furthermore, once the deductible has been reached, the full cost of dispensing the prescriptions will be borne by the individuals and families.

These changes not only represent a power grab but a fundamental shift in principles and values for Ontario. They do nothing to improve the health care system.

User fees, deductibles and copayments for prescription drugs will not reduce the need for prescription medicine, but it will reduce the number of prescriptions filled by seniors and families with limited incomes. It will increase the need for crisis intervention, hospitalization, long-term treatment and other social services.

For example, patients who have been released from psychiatric facilities often need tremendous community

support. Monitoring their medication compliance is crucial. A user fee will restrict their access to the drug therapy programs that make them well and keep them well. Introducing a \$2 prescription fee to patients who may require as many as a dozen prescriptions will put them at risk to do harm to themselves and others. More likely, they will end up on the street, in jail or back in the hospital.

User fees shift the blame for the high cost of the drug program on to the victims—senior citizens and those on social assistance—when the responsibility lies mostly with governments, doctors and the drug companies.

The existing act requires the Ontario drug benefit plan to reimburse an eligible person for the full costs of the drug where a physician has specified that no substitutions are to be allowed. Under Bill 26, the eligible person would be responsible for paying the pharmacist for the cost of the difference between the specified drug and what is deemed by cabinet regulation to be an interchangeable product.

This bill gives cabinet virtually unfettered power to enact regulations establishing user fees and copayments, which could lead to charges that differ substantially in method and amount from those that have been recently announced. It also gives the Minister of Health wide power to collect, use and disclose personal information for purposes related to this act or for any other purpose defined by regulation.

All of these regulations seriously impact on the universality and accessibility of health care services, of medically necessary medication and treatment, for people who need support.

Ms Monteith-Farrell: Changes to the Prescription Drug Cost Regulation Act: The name of this act is changed to the Drug Interchangeability and Dispensing Fee Act because the Minister of Health will lose the power to regulate the price of drugs for anyone not covered by the ODB. Some 60% of all prescription products sold are for people who are paying on their own or through an insurance plan.

Manufacturers will be free to determine the price for drugs, other than for drugs provided under the ODB, and prices will certainly go up. As well, there will be impacts on the uniformity of pricing, particularly in remote locations, where they may seriously escalate.

In the multinational world of drug manufacturing, competition will not be a control factor in keeping prices down because of the patent protection of Bill C-91.

People fortunate enough to find or keep employment that pays well enough for them to be exempt from the Trillium program will pay more for their drugs. Those who benefit from insurance plans which cover drug costs will have to deal with the impacts of increased premiums, employers as well as employees.

It is easy to see who will benefit and who will lose under the amendments to these acts.

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Schedule H amends the Health Insurance Act and the Health Care Accessibility Act.

Bill 26 removes all references to "medically necessary" services and substitutes a broad power in cabinet to decide which services will be insured. This opens the

door to establish delisting of services. The government will be free to determine whether medically necessary services are insured services or not.

The cabinet has the power to determine the types of services provided to persons in a prescribed age group. The intent of this clause is unclear, but there is nothing in Bill 26 that would prohibit persons in their 60s to be refused open heart surgery, based on age.

Cabinet has the power to determine if the services are medically or therapeutically necessary.

Cabinet has the power to unilaterally establish the basic fee payable for insured services.

Bill 26 gives the minister and general manager of OHIP the power to collect and disclose patient information for any purpose that may be prescribed. This opens the door to privatizing OHIP administration and giving personal medical information to private corporations.

Bill 26 amends the Health Care Accessibility Act to apply to hospital insured services. It gives explicit statutory authority to cabinet to make regulations that would permit hospitals to charge patient user fees for any hospital-based insured services, including those presently covered by OHIP. Examples of user fees would include accommodation and meals, necessary nursing services, laboratory and other tests, drugs and emergency room visits.

Mr Armstrong: Schedule I, Physician Services Delivery Management Act, 1995: This is a new act introduced in Bill 26. Bill 26 grants the cabinet power to extinguish contractual rights or obligations contained in various agreements entered into between the government and the Ontario Medical Association. These include the various existing alternative payment plans or non-fee-for-service agreements.

It strips the OMA of any negotiating rights and says the judge's ruling, decision, award or order "shall be of no force or effect."

Together they provide the government with enormous powers over doctors. The Minister of Health can restrict the number of eligible physicians, determine that a particular area is oversupplied and impose a moratorium on new physicians in that area.

The amount paid for services will be varied, depending on the geographic area or other factors.

One amendment to the Health Care Accessibility Act, subsection 2(3), may open the door for hospitals to expand their user charges for such items as toothpaste.

The Physician Services Delivery Management Act treats doctors like the Leamington mushroom workers, who were decertified with the repeal of the Agricultural Labour Relations Act. It voids the OMA's agreements, strips the OMA of any negotiating rights and says any judge's ruling, decision, award or order to the contrary "shall be of no force or effect."

The Chair: Excuse me, I'll just make you aware of the fact that you're down to three minutes.

Mr Armstrong: Okay. There are schedules I, J, K and Q that we had wanted to speak about, but you can read them at your leisure.

During the 1995 election we heard promises from Mike Harris and his Conservative cronies. The promises on health care are in print and were said to be sacred.

The promises voters heard were clear. The Conservatives said, if they formed the government: "We will not cut health care spending," that "health care spending will be guaranteed," that "health care funding won't be touched," that "aid to senior citizens and the disabled will not be cut."

"How we achieve the savings," they said, "will be discussed in a partnership with all Ontarians. Our four-year plan is based on four years of study, analysis and consultation with workers and ordinary Ontarians through extensive public hearings. We've looked at user fees, copayments and delisting but decided the most effective and fair method was to ask individuals to pay a fair share based on income. There will not be user fees. We will work with OPSEU members, listening to their ideas and eliciting their help in taking action."

Bill 26 breaks each and all of these promises. It will destroy Ontario's health care system and it will put people at risk.

In conclusion, Bill 26 represents the most authoritarian power grab in Ontario's modern history. It is an affront to democracy and a disgrace. It follows the same course of action the government followed in Bill 7: a swift introduction and passage of the legislation with little opportunity for public input and hearings. It verges on fascism with its sole discretion of the minister and immunity to any court processes.

Bill 26 is the thin edge of the wedge to Americanize our health care system. It repeals the Independent Health Facilities Act language which gave preference to our Canadian-style non-profit operator. It gives the minister singular power which raises the real possibility that for-profit US health care providers will be licensed to provide health services in Ontario. Studies I have read and comments from our American sisters and brothers show us that the American corporations are extremely interested in our health care system. These corporations call our health care system the "unopened oyster" and they refer to the elderly as "mining grey gold."

I am old enough to remember my grandparents and parents talk about families becoming destitute when a family member became ill before we Ontarians and Canadians had universal medicine. No one wants to go back to those times.

The only positive comments we have heard in north-western Ontario are from rural communities which are desperate to get doctors. We support that need. However, the end does not justify these means.

Bill 26 should be withdrawn. The government should conduct extensive hearings and produce changes desired by the populace. The majority of Ontarians did not vote for this government. It should not rule like a dictator.

Bill 26 should be withdrawn. If it is not, it will become the rallying flag for the citizens of Ontario. It is already the rallying flag for the Thunder Bay and District Labour Council and its affiliates.

The Chair: Thank you for your presentation. We appreciate your interest in the process. You did not leave any time for questions. Good day.

Mrs McLeod: I'd point out that a number of people have been standing for some time. Could the hotel be asked if there's any way to put a few more chairs in the room?

The Chair: I don't see a lot of room to put any but in the corners.

Mrs McLeod: I don't think we're at capacity in terms of numbers of people. It's just a place to find some chairs.

The Chair: Okay, we'll ask the question. Thank you very much.

Ms Lankin: Mr Chair, may I place some questions on the record, please?

The Chair: Yes, you may.

Ms Lankin: Thank you very much. I think, because there are so many aspects to this bill, we haven't been able to have presenters focus on certain areas, and I'm concerned that we may not get full information, particularly with respect to the Independent Health Facilities Act. These last presenters raised some important issues. So I'd like to place some questions to the ministry.

The changes to the Public Hospitals Act and other areas in this bill allow the minister to determine what services will or won't be provided in any particular hospital. Is it possible that services that the minister determines will no longer be provided in a certain hospital will be moved and/or provided through an independent health facility?

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Is it possible under this new legislation that a profit-making American company could become the owner and/or operator of an independent health facility?

Is it possible under this act, as you will be amending it, that the minister could contract directly with such a for-profit American company without going through a tendering process?

Is it possible that that company could be the likes of an American for-profit health maintenance organization, or HMO as they are better known?

The Chair: Ms Lankin, this is beginning to look a little bit like a speech.

Ms Lankin: No, it's not. These are questions. I have specifically written them down. They are questions that I want answers to and this is an appropriate process, Mr Chair, and I'm not abusing it.

The Chair: Okay.

Ms Lankin: Could you indicate to me for such a for-profit company where in the margins of operation the profit would be found? Specifically, I'd like information on the use of facility fees and the OHIP billings.

I would be interested in having a list, if there are any, of any American for-profit companies or their Canadian subsidiaries, I should say, that the minister has met with or spoken to. If I cannot get the information provided through this process, I will file an FOI. I know it could be made available through that process, so I'm trying to short-circuit it and ask you to cooperate on that.

The Chair: Is there some end to this list, Ms Lankin?

Ms Lankin: Yes.

The Chair: We do have people waiting to make a presentation.

Ms Lankin: Mr Chair, you know the only way that questions can be asked of the ministry and put directly on the record is to be done this way. I'm doing it very quickly. I have two other questions on another matter, and it'll be very quick, and that's with respect to the

concerns raised around the privacy of information and the use of such information.

Would those provisions, as they're being changed in the act, allow for, as the speakers indicated, the privatization of OHIP management and that information to be therefore managed by a private firm, and/or the production and management of the health card, particularly if we moved to smart card technology? Would these changes pave the way for that kind of event?

That's it. Thank you very much, Mr Chair.

The Chair: Our next presenters are the Lake Nipigon—

Mrs McLeod: Mr Chair, I'm sorry to do this to you. I'll ask Lake Nipigon to have 30 seconds' more patience. As you're aware, there are a number of people who had wanted to make presentations to the committee and are not able to. I assure you I'm not about to ask for further consideration, but there's at least one individual here who had hoped to make a presentation and has a written brief. I'm wondering if the clerk could make this written brief available to each member of the committee.

The Chair: I would be more than happy to do that. Anybody who has a written brief, the committee would be happy to entertain it.

Mrs McLeod: This is a brief from the executive director of the Atikokan General Hospital.

LAKE NIPIGON REGION HOSPITAL ASSOCIATION

The Chair: The Lake Nipigon Region Hospital Association, represented by Judith Harris, the CEO of the Manitouwadge General Hospital. I'm sure I don't have the other names. If you could introduce yourselves, we would appreciate it. You have 30 minutes to use as you see fit. Questions would begin with the New Democrats. The floor is yours.

Mr Donald Ross: Hello. My name is Donald Ross and I am the chief executive officer of the Nipigon District Memorial Hospital. Dr Mary-Lynn Jackson-Hughes is the chief of staff of the Nipigon hospital as well as the coordinator of Family Medicine North. Judy Tinnes is the chairman of the Nipigon-Red Rock Healthy Communities Committee.

Thank you for the opportunity to appear before the committee to discuss the Lake Nipigon Region Hospital Association's concerns regarding the Savings and Restructuring Act, Bill 26.

The Lake Nipigon Region Hospital Association is comprised of five hospitals located in the Lake Nipigon riding. They are Geraldton District Memorial Hospital, representing Geraldton, Nakina, Longlac, Caramat; Manitouwadge General Hospital, representing the Manitouwadge-Hillsport area; Wilson Memorial General Hospital, representing the Marathon-Heron Bay-Mobert area; Nipigon District Memorial Hospital, representing the Nipigon-Red Rock-Beardmore-Dorian-Hurkett area; and the McCausland Hospital, representing the Terrace Bay-Schreiber-Pays Platt-Rossport area.

To give the committee some idea of the land mass of the Lake Nipigon riding, it could easily fit in the area from Toronto to Chatham and north to Owen Sound. It has a population base of approximately 30,000 people.

Like the Ontario Hospital Association, the Lake Nipigon Region Hospital Association cannot support those sections of Bill 26 concerning certain amendments to the Ministry of Health, the Public Hospitals Act and other health acts. The Lake Nipigon Region Hospital Association fully supports the concerns and recommendations provided to you by the OHA and OHA Region 1. Rather than reviewing with the committee the details of these concerns already placed before you on other occasions during your hearings, please allow me to tell you about a success story.

Lake Nipigon Region Hospital Association has been in place in one form or another since 1978. The purpose of this association is to:

(1) Provide advice and recommendations to each member hospital board of governors on issues of common concern and interest to improve the efficiency, co-ordination and quality of services provided both individually and collectively.

(2) Strategically ensure that the members of the Lake Nipigon Region Hospital Association can proactively respond to changes in the delivery of health care services on a timely basis.

(3) From time to time, recommend to member hospitals the need for studies to address specific issues.

(4) Communicate and share pertinent information that will assist member hospitals either individually or collectively.

Given the geographic and climate conditions experienced in the Lake Nipigon riding, you can appreciate the deep commitment required by all the communities to ensure the success of this association. The association shares four major programs on a global basis within our association: laboratory, pharmacy, dietitian and occupational therapy. The association also assisted and promoted the development of a vertically and horizontally integrated health care system in each of our communities.

Our institutions are not traditional hospitals but are community health care centres which support a significant number of community-based programs. A list of the services and activities of the Nipigon District Memorial Hospital, attached in appendix I, is provided to you to further emphasize this community's attitude, supported by its own dollars, towards an integrated health care system. We use Nipigon as an example only; all five communities have similar systems in place.

In our communities we also have in place healthy community committees consisting of intersectoral, interdisciplinary and volunteer public members who work together addressing health, social, environmental and economic health issues for our communities. This integrated community model of services and programs provides coordination of community and institutional services, focuses on health promotion and disease prevention, and at all times encourages public participation and commitment in the planning process.

These committees look for and monitor both duplication and gaps in services and then jointly try to find solutions. Specific programs and services are rarely planned in isolation, even though many of our agencies and institutions are operated and funded independently. Appendix II demonstrates the comprehensive membership of these committees.

We are concerned that the three-year hospital funding reductions do not take into consideration the comprehensive nature of our health care systems. If I could ask the committee to turn to appendices Ia and Ib, you will see that Nipigon District Memorial Hospital delivers a comprehensive range of patient services. They range from acute care to nursing home beds to ambulance services to home care programs to Handi-Transit services. They are integrated and administered by a common hospital support system. Hospital funding reductions will impact not only on traditional hospital services but also on a variety of community-based programs, and a reduction of community-based programs will, in turn, increase institutionalization.

Secondly, in all of the association's committees, community-based programs are of low volume and rely on the support services of their local hospitals. If funding reductions force hospitals to cut back, limit or suspend community-based programs, they simply won't be delivered, or they will be, at a much higher cost, by a distant central agency.

The association requests that the government understand this unique system and be sensitive to it when considering funding reductions.

We have achieved these successes in spite of the barriers placed before us, such as the silo structure of government and its agencies, funding constraints, lack of physicians, as well as geography and climate. We suspect our health care system in our Lake Nipigon riding is closer to the concept of one-stop health care than any in the province.

I would like now to ask Dr Mary-Lynn to make some comments on the physician shortage.

1110

Dr Mary-Lynn Jackson-Hughes: I'll just tell you a little bit about myself. My husband and I are in practice in Nipigon, which is a small community of 2,500 people. It's 100 kilometres east on the Trans-Canada Highway. We came up through the underserved area program to stay two years and we are now in our 20th year of practice in Nipigon. We very much have enjoyed living there, raising our family there and we would like to continue to practise there.

I personally have been intimately involved in all the problems associated with physician recruitment over the whole 19 years. In fact, I've met a lot of you on recruitment tours where we go stomping down in southern Ontario to all the major cities.

You know and you've heard and you're very, very aware of the problems in these small communities, and it was recognized with the \$70-an-hour sessional fee—absolutely fantastic and we thank you in the small communities because it is going to make a difference. It is time now, though—I think the studies are all completed, the rest of it—for implementation of recommendations that I know are before you, specifically the Scott report and especially the alternative method of payment.

Another solution I feel to the problem is support of the NOMP undergraduate and graduate training program through Family Medicine North. It has been well documented that physicians who train in the north stay in the north. We have been involved, and I personally have

been involved, for 19 years. The program has been involved locally here for 25 years. We're doing a good job and we want recognition that we have done a good job, and please let us go on and continue. Thank you.

Mr Ross: We in the Lake Nipigon riding have never accepted the status quo and we are always continuing to re-evaluate our service and ensure they are in concert with those of the Ministry of Health and government. In December, the Lake Nipigon Region Hospital Association initiated a comprehensive re-evaluation of the region's health care system to further identify savings and improve efficiencies. This study is funded by the member hospitals.

Although supportive of the need for significant changes, our association is concerned that some of the new powers given to the ministers and civil servants under Bill 26 may not enhance our association's work and could potentially impede it. If changes are not made to Bill 26, or if its power is inappropriately exercised, it may (a) undermine volunteer governance of health care; (b) allow for the micromanagement of front-line operations; (c) restructure services, programs and institutions in an irrational manner; and (d) minimize due process and fairness.

Our association agrees with the Ontario Hospital Association's five goals:

(1) To preserve and enhance the system of volunteer governance of health care by community representatives;

(2) To maintain and improve the quality and accessibility of the health care system and to increase accountability for the public dollars expended;

(3) To ensure that regionalization initiatives are based on population needs and the creation of systems of care which reflect delivery capabilities and effective referral mechanisms;

(4) To maintain the hospital system's ability to manage human resources effectively; and

(5) To develop new approaches to funding hospitals and related physician services in order to improve health services across the province.

I have attached for your review the OHA recommendations that were provided you to on December 18, 1995.

In summary, the Lake Nipigon Region Hospital Association is aware that bringing the deficit and debt under control is a requirement and we are pleased to contribute our energies towards that effort. We applaud the intent of Bill 26 to facilitate change but are concerned that in its present form it may endanger the most positive aspects of our health care system. Appropriate safeguards are required to prevent that.

The Lake Nipigon Region Hospital Association opinion is that most of the problems facing small hospitals are well documented. Many of the solutions to these problems are identified in numerous reports: The Scott report; the OHA rural study, Small Hospitals in Ontario: Towards the Year 2000; Access to Care in the North are just a few I could name. The evaluation process should now be over and the implementation phase begun. It is the association's hope that government will be sensitive to the north's solutions to its unique problems and funding requirements and act on them accordingly. Thank you very much for listening.

The Chair: Thank you. We have about five minutes per party left for questions, beginning with Mr Pouliot.

Mr Pouliot: I thank you very kindly, Mr Chair. You will allow me perhaps a departure from form to say briefly—however, sincerely—how pleased I am when I see the heading of Lake Nipigon, but more importantly, I see Mme Tinnes, Dr Jackson-Hughes and Mr Ross, who have been closely associated. We have fought many battles of many kinds over the years.

I'm a little surprised, having said this, to find my three most distinguished constituents sounding a lot more moderate than their representative. You'll hear. My first question will be directed at Don—Mr Ross.

Mr Ross: Not moderate, wiser.

Dr Jackson-Hughes: We've learned over the years. Is that what we're saying?

Mr Pouliot: Mr Chair, will you please assert your authority?

People will do that, and I'm sure the members have been blessed with synonyms or words that are often repeated, such as "Our situation is unique," "Oh, but we're more special than others." Suffice it to say the riding of Lake Nipigon certainly has a claim, and you've mentioned it, and very well indeed: 26% of the overall land mass of the province, the size of Germany. I live in Manitouwadge and I'm closer to Toronto than I am to some parts of the riding of Lake Nipigon, and when in Toronto closer to Miami. One can go on to illustrate about, if not its uniqueness, the fact that ridings such as Kenora, with my good friend Mr Miclash, are dependent. There's really no alternative here. And people have been very, very cognizant. They've acquiesced readily the time to change, because we change just to survive.

You've mentioned about three years' funding. You've shown a concern. I was watching you carefully and listening intently indeed. Can you give me in your own words, Mr Ross, an example of what would happen if funding would be negatively impacted? You're a hospital administrator. You know first hand. You see those things on a daily basis.

Mr Ross: And Mr Pouliot will want a straightforward answer. If we were to receive, in our small hospitals, an 18% across-the-board decrease, it would literally destroy the network that we have spent the last 15 years developing. I have some doubt, and I have not worked through the process in my own hospital, I'm not so sure that we can survive the 5%.

Our problem, I think, in terms of funding is that the funds we receive are based on traditional hospital methodologies, and we are no longer a traditional hospital. Our system has developed into an integrated one.

Let me give you an example. We have a Handi-Transit program in Nipigon which is solely funded, totally, 100% funded by the community, through Lions clubs and volunteers. That program is extremely important to support our medical day care program, because the greatest barrier bringing people in for medical day care is the transportation.

If one of those two programs were not be funded, for whatever reason, what would occur is that those people would have to go somewhere, and I can tell you where they'll end up. They'll end up in the acute care portion of

our hospital, which will then just force up costs, greater than they were in just subsidizing the other two.

We also, through our hospital budget, make the conscious decision at times to fund non-traditional services. If we need to expand home care a little bit, we as a hospital will contribute money to keep this very important program going.

We receive our funding based as a traditional hospital. We have developed over the last 20 years, I think developed in the direction Mrs Lankin had wanted us to go and Mrs Caplan had wanted us to go and Mr Timbrell had wanted us to go over the last decade and a half. I have a great fear, unless somebody pays attention to this problem, that our total network could be destroyed, and I think the ultimate end goal will be increased costs.

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The Chair: Mr Pouliot, I'd love to listen to some more questions from you but your time is up.

Mrs Ecker: Any riding that can produce a representative as unique as my honourable colleague across the way is indeed unique.

Ms Lankin: Wait a minute here.

Mr Miclash: Was that a shot?

Mrs Ecker: It was a compliment, without at all wishing to be provocative.

Thank you very much for taking the time to come today. We've heard, I think, some very useful input from the hospital sector, as we've done in these hearings, and I think the other thing is that most of the presenters have taken the time to provide some very useful educational information to make sure that we all are very familiar with the concerns and the needs that are here.

I would share with you your urging to get on with implementation, that the time for studies is over. We've read them, we've seen them; they're all very consistent in some of the recommendations that they make.

I guess when we talk about underserved areas and getting physicians attracted to the north, retaining physicians in the north, it's a problem that all three governments in the past have wrestled with. I think that some of the past governments' representatives here might find it a tad ironic that they had actually looked at things like fee differentials, fee discounting. There was great angst about that, and that wouldn't work, that was a problem, and yet we've had presenters come forward who say, "No, no, no, don't do billing numbers, do fee differentials," or discounting in fees.

There are lots of suggestions that have been played around with, and I'm sometimes left with the impression that without some kind of big stick, without some kind of need to push the change, it's not going to happen, the problem is not going to get solved, because we've seen it not being solved despite a lot of good efforts by a lot of people from many, many stakeholders.

We had PAIRO, the interns' group, presenting to us. They're launching what sounds to me to be a very good initiative, working with the communities and their colleagues and the graduates to try and get physicians in there. I was left with the question about, this sounds really good, this sounds like it might really work, but where was that a year ago or two years ago or three years ago when the problem was just as severe?

I get the sense that we've run out of time, that it's getting worse, and that without some power, some push, some stick, something that gets it solved, it's not going to happen. With your great experience that you've had in this field and wrestled with and everything else, do you have any comments or suggestions or advice for us as we continue to try and resolve this problem?

Dr Jackson-Hughes: I personally think that you can't have a stick, you have to offer a carrot. To me, you have to have the incentive. You have to have people wanting to come to these communities. You can't have them forced there because of billing numbers and the rest of it.

I don't want someone to come into Nipigon who couldn't practice in Toronto or Chatham or whatever. I want someone there because they want to be there, because they want to raise their family in a small community. You need to have—and unfortunately, financial incentives help. It's not the only answer. You have to look at spousal retainment and lots of other problems involved in retention.

But I can't agree with the stick. I'm sorry, it's my own personal—

Mr Ross: I would also add to that, probably one of the best government reports I've read in 20 years is the Scott report. The Scott report really says there is no one single solution to this problem. In order to solve it, you have to have whatever number there are, the six or seven or eight major prongs to that report must be in place all together at the same time to attempt to solve this problem. You can't take just one of the areas out and say: "Hey, I've done my thing. Things are going to go along." You have to take the whole package and implement the whole package if we ever hope to solve this problem.

I can tell you, a great deal of my time over the last 20 years has been spent in recruiting physicians, and it has never been so difficult as it has been in the last four years.

The Chair: Mr Miclash—oh, Mrs McLeod.

Mrs McLeod: I'll lead off because my point follows on the issue Ms Ecker was raising. I have repeatedly expressed my frustration at the suggestions of the government that it now needs to come in with the threat of billing numbers and coercion because nothing is working. Obviously, you've been very involved in the underserved area program and some of the frustrations in getting it enhanced and improved, because it can be made to work. The residency training program which you've talked about this morning is recent in terms of its graduates. I just checked, and the retention rate for that training program is 67%. That is unheard of in terms of our ability to use a training program to retain physicians in northern Ontario. So there are programs that are working.

What we heard in other communities was that we need a comprehensive program, which is the point that Don Ross is making, and there are ample recommendations. In fact, we had an outstanding brief in Sudbury yesterday presenting a complex set of recommendations and following up on the Scott report.

We also heard that the threat of billing numbers, combined with other interventions of government, or threatened interventions of government in the way in

which medicine is practised, will set back the positive process of recruitment significantly and holds the threat of both new graduates and established physicians leaving northern Ontario. I guess I would just ask for your further comment on that.

Dr Jackson-Hughes: I wholeheartedly agree with you, Lyn. Personally, if things like that, billing numbers, came in and they were imposed, it just takes away any freedom you have of where you want to practise medicine, and it's wrong. It's not right.

I keep emphasizing that you have to want to come. Part of it is, train in these small little communities. Get over your fear of what's going to happen medically in the emergency department.

All those things are working right now, and you add a few more of the Scott report recommendations and I think your problem's going to start being solved.

Mr Ross: That's why you have to pay close attention to the Scott report, because if that Scott report is not implemented, or some form of it, you may find yourself using the worst tool possible, and that may be billing numbers. That's how important that Scott report is.

Dr Jackson-Hughes: You're going to have a revolving door of physicians in these small communities. They come in, they spend their two to three years and they're right out again. I want people there. Our retention rate in Nipigon is one of the highest in the area. We have five, eight, 10, 15 years, and my husband and I 19 years, because of what we have to offer: our lifestyle.

Mr Miclash: We've been hearing that the government has suggested that hospitals such as the one that Don runs should earn revenues through the assets of the facility. I would just like to ask for some input from Don. Earlier today we heard from two other administrators from small hospitals who were concerned, as you were, about funding cutbacks. But what do you feel about this whole idea of the earning of revenues through your facilities?

Mr Ross: We do it. We do it very actively. We run, I've forgotten the number now, five or six businesses, with gross expenses of somewhere between \$600,000 and \$700,000 and a net profit of about \$140,000, but I think we're at the maximum. When I hear that hospitals should get into this business and they can earn more revenue, I say, "My goodness, I'm already there."

I've got to tell you, as a hospital administrator, I don't like it. I seem to be spending less time as a hospital administrator and more time as a private business. I have to be concerned, in a small town, that I'm not in competition with the only dry cleaner. Is it my objective to put him out of business?

Mr Miclash: I hope the government's listening.

Mr Ross: A whole slew of problems associated with it, but at the same time for small communities that have not participated in this, there is room to move. But I'm concerned that in our particular area we're very active right now. On the other hand, I have to tell you that I'm a hospital administrator; I'm not a small businessman.

The Chair: Thank you very much, folks. We appreciate your presentation this morning. Have a good day.

Mrs McLeod: Can I take 30 seconds to provide the committee with some information? I think it's of interest. We've had several regional hospitals present today and

the OHA District 1 chair brought along what is the sole map that has the entire province of Ontario on one page other than an MNR map of provincial parks.

It's yellow with age. I wanted to just present it to the committee. I think it dates back to about 1926, but it does show you, I think graphically, what we're talking about today. We leave northern Ontario this afternoon, as you know, and fly to Ottawa. We have been discussing for the last three days this entire region of the province of Ontario, and I think what every presenter has said is that you've got to understand the geographic realities of the province of Ontario to know what unique northern health care needs are.

1130

AIDS COMMITTEE OF THUNDER BAY

The Chair: Our next group is the AIDS Committee of Thunder Bay, represented by Michael Sobota, the executive director, and Robert MacKay, a member of the board of directors. Good morning and welcome to our committee. You have a half-hour to use as you see fit. Any questions that you leave time for would begin with the government. The floor is yours, sir.

Mr Michael Sobota: My name is Michael Sobota. I am the executive director of the AIDS Committee of Thunder Bay. Mr MacKay is unable to co-present with me due to personal reasons.

I feel, as I sit here, that I've just won Lotto 6/49. Being able to be in this chair is an extraordinary privilege. I am aware, as I sit here, of the people behind my back, not just in this room but outside of these walls, who don't have this privilege. I feel their tension, I feel their presence and I feel their pressure as I'm about to speak to you. Thank you for allowing me this time to be here.

You have my brief in front of you. I'm going to quickly scan the executive summary with you. It is not possible in a half-hour to talk about all of the things we want to talk about. We would like to speak to you next week on the non-health issues as well because they do impact on our work, but we opted to attempt to get into this round of the deputations.

If you'll quickly look at my executive summary, I would like to just put on the record the topics that are covered in the brief. The subjects we look at are economics rather than health; community consultation and building on past work; a concentration of powers and authority; the removal of liability or appeal; privatization of Ontario health care; privacy and confidentiality of medical information; authorization to municipalities to dissolve boards of health; direct costs to people living with HIV/AIDS; and an atmosphere of insecurity, fear and polarization.

It's been paramount in our analysis of the bill to look specifically at how Bill 26 impacts on the lives of people who are living with HIV or AIDS and also how it impacts on the work of community-based AIDS organizations.

You need to know quickly a couple of other hats that I wear. It's been my humble privilege and honour to serve under five different ministers of Health as an

adviser to them on the subject of AIDS, spanning all three major political parties.

I was pleased to be appointed the co-chair of the minister's Advisory Committee on AIDS under then-Minister Frances Lankin and I'm currently sitting on the Honourable Jim Wilson's Ontario Advisory Committee on HIV/AIDS. He acknowledged my work on the floor of the House last October during AIDS Awareness Week. It's a context you need to know as I begin this.

Economics rather than health: Right from the first paragraph of Bill 26, the language and its objective is economics. Subsequent sections grant the Minister of Health and other ministers sweeping powers to act when the minister "considers it in the public interest to do so." But public interest is seen as singularly economic. Fiscal issues are important and even critical, and we acknowledge that, but within this legislation they're the only criteria for action.

There are clear dangers that the Minister of Health may be forced to make decisions that are economic only and not related to the health of Ontario citizens. The Minister of Health needs to be an advocate for health at the cabinet table. The bill makes the minister a financier first and foremost, almost subservient to the Minister of Finance. The bill embraces an extremely narrow view of reform, restructuring and change, that of economic restraint.

Community consultation and building on past work: We acknowledge there's a need to get the province's fiscal house in order, but in the desire to fix fiscal problems this legislation creates more problems. We believe that both health and fiscal responsibility can be achieved. There have been numerous previous studies and consultations that have addressed these issues. Many people who spoke to you here before me have already addressed that. This bill demonstrates little of what we have already learned.

A primary example is the general recognition that we need to shift health more to the community to provide a continuum of care from hospital care to home care. Each health agency or institution has an integral role to play, as restructuring occurs to shift the balance from higher-cost institutional care to lower-cost community support. This shift is already in process. Community-based AIDS organizations, community health centres and community mental health organizations are all examples of this shift in process.

There has been important recognition of community involvement in setting direction, and there needs to be more of this. An example is the previous consultation process and review of the Public Hospitals Act, where many people spoke of the need to make hospitals more accountable to their communities. This bill makes them accountable to the minister and to cabinet. This is moving backwards.

Concentration of powers and authority: If passed in its present form, Bill 26 will vest in cabinet and ministers the unconstrained power to make decisions affecting the delivery of public services—in the instance of health, what kind, how often, at what cost—together with the operation of public health institutions—whether hospitals will stay open, boards of health will reduce or change

services or simply cease to exist. In most cases these decisions can be made by regulation, ministerial direction or administrative order without parliamentary debate or meaningful opportunity for public scrutiny and without community, local or stakeholder input.

Let's establish clearly here that these remarks about the concentration of powers are not personal to Mr Wilson or to other ministers. The powers granted in the bill are generic and that's what we are reacting to.

The serious dangers of decision-making by one individual, the minister, or a small group of individuals, cabinet, in isolation, should be obvious. Bill 26 moves us backward to a system of dictatorial authority and imposition of decisions rather than consultation in partnership. At the least, this fosters an atmosphere of tension, frustration and distrust; at the worst, people's lives may be at stake from uninformed or mistaken decisions. The central question here is how can a single individual, or even cabinet, possibly understand the full impact on the personal or community level of health care matters without meaningful community input?

Removal of liability or appeal: In the complexity of Bill 26, by my analysis there appear to be at least 13 areas where the government is giving itself the right of final appeal, thus removing any possibility of review by independent third parties, the Legislature or the courts. This, coupled with the concentration of powers previously mentioned, is very troublesome and doesn't make ethical sense.

If the government is convinced that these unilateral powers will be used justly and fairly—if you believe that, what have you to fear from third-party review? What is there to be afraid of in letting the Legislature debate your decisions before they're implemented, if you really believe that? This too contributes to a generalized atmosphere of distrust and insecurity that Bill 26 engenders.

Privatization of Ontario health care: The changes to the Health Care Accessibility Act, section 22, remove the preference given to non-profit Canadian sources or institutions. Our fear is that this is a clear shift towards an American medical model. One characteristic of that model is the belief that the market brings out the best in everything. We fundamentally disagree with this philosophy in application to health care. In health care the market does not produce the best for the greatest number of people.

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An example exists currently in the public insurance industry. This example relates directly to the field of HIV/AIDS. If you wish to take out life insurance of a certain threshold amount, usually anything above \$100,000, you're required to submit to a number of health tests, including the antibody test for HIV. In Ontario HIV antibody testing is done by a blood test processed through our provincial laboratories. The public insurance industry, which is essentially self-regulated, allows a required HIV antibody testing to be done from a urine sample rather than blood for economic savings.

Ontario, together with eight other Canadian provinces, does not allow urine testing as it's far less reliable than the basic blood test. The insurance industry gets around

this ban by shipping urine tests for processing to the only province where it is legally accepted: Quebec. This process is notoriously flawed and has resulted in unnecessary stress and anguish for people who access our services, who have received false or otherwise inaccurate test results because of insurance-mandated testing and the private system they use to get around our provincial testing laboratories.

We are very worried about the potential reduction or loss to our regional public health laboratories. The for-profit motive of commercial laboratories does not operate with the interests of patients as its standard for existence. While commercial laboratories are generally competent businesses capable of carrying out a range of professional services, there are none the less well-documented problems of consistency, standards and processes.

Let me share with you a local example. In more than one instance our clients have reported to us that they've had to go back and duplicate blood samples drawn at a private medical lab, as the lab's transportation procedures could not deliver blood to the nearest equipped centre for its processing in time for it to be usable. Essentially it was wasted, and our clients had to go back to the lab and have blood taken a second time. People living with HIV require more than usual testing, many requiring blood to be drawn. For them to have their blood wasted, and that's the net result of what this private laboratory processing procedure was, was unconscionable, adding unnecessary stress to already burdened immune systems.

Our provincial laboratory system, specifically in terms of HIV surveillance, is one of the finest on the continent, if not in the world. It is the envy of the Centers for Disease Control in Atlanta. I know this from feedback at international AIDS conferences. Ontario has been a leader in building one of the earliest and best systems to get hold of this epidemic, to be able to bring into focus what's now called "the natural history of HIV."

This is accomplished within our public laboratories through years of dedicated experience and expertise, through systems and data collection improvement, through enlightened government and public support, and here I include the utilization of the provincial anonymous testing system. Ontario's anonymous testing system collects the most comprehensive data and has been the envy of American and other centres for AIDS control.

HIV surveillance, that is, testing, data analysis and report-generating, is simply non-existent within the commercial laboratory system. An example here is the Western Blot test, used as the standard for confirmatory testing to determine a positive HIV antibody test. It's not done commercially, and that's probably because the test is labour-intensive and expensive.

The costs of shifting this to a commercial system would be prohibitive. It will cost you more to do that. A comparable test also would be hepatitis, and please check these figures out for yourself and do some research about this. Our public laboratories can do this for approximately \$5 or \$6 per test. Private laboratories cannot deliver it for this amount. Check this out and verify it.

Proponents of Bill 26, in their intention to drive decision-making on economics, should tread cautiously when addressing the complex services of our public

laboratory system and on the exemplary record they've compiled over a decade of working with HIV surveillance. This is so crucial, that this could be lost in our struggle with HIV in the province.

Privacy and confidentiality of medical information: It has been elementary to Ontario citizens from the time we were kids and we first went to the doctor, our first access to health care, that our personal medical information was private. We were told that. That's part of how we get to feel okay about going to the doctor, that you can talk to your doctor, that it's a safe place to be. Privacy and confidentiality of medical information is a basic, sacred trust between governments and its citizens. Bill 26 is a breach of that trust.

This section alone has raised acute fears and questions from people living with HIV and AIDS. A prominent person living with HIV put it most simply and eloquently. He said, "What does the minister need my medical information for?" This, coupled with the protection the bill provides from damages caused by the release of medical information, is causing a profound sense of insecurity and an atmosphere of fear within our work. It particularly damages our ability to gain and maintain the trust of young people and others already marginalized by mistrust of institutionalized care and bureaucracies.

This single element does profound damage to years of hard and dedicated work towards attracting people living with HIV into the health care system. It destroys all the principles with which we encourage people to seek anonymous testing, counselling and, where appropriate, connecting up with a primary care physician. Anonymous testing was built on the principle that you'll be treated with respect and utmost protection. That sense of protection and respect is violated by the legal authority to breach confidentiality and make public what was private medical information.

If we lose the momentum we've worked so hard for for over a decade towards bringing people who are infected with HIV into our health care system, you can expect two practical and direct results. There will be increased transmission of HIV and there will be greater, not lesser, health care costs.

Again, we reaffirm our respect for the present Minister of Health. He has gone on the record saying that AIDS is a priority within the ministry, but structures and policy should not depend on any single individual. This section of Bill 26 may be the clearest example of where the legislation is motivated by economic considerations, to the neglect of other profoundly damaging implications.

I want to jump to my section 8, the direct costs to people living with HIV. The imposition of mandatory prescription user fees, the moves to restrict and reduce drugs available on the formulary list, the imposition of user fees by municipalities—which you'll hear a lot about next week—all add direct dollar costs to people who are already struggling to make their financial ends meet every month. The impact on people living with HIV is to add stress and expense to their daily living, which is already complicated by maintaining a delicate balance of quality of life with a terminal illness.

One of the primary stressors to people living with HIV is whether new treatments, those chemical equivalents of

hope, will be accessible and affordable. We expect the measures in Bill 26 to add pressures to our agency's emergency financial assistance program, which are private, fund-raised dollars that we raise ourselves to assist people facing emergency financial needs that are not met from any other source. This is already happening.

An atmosphere of insecurity, fear and polarization: Taken as a whole, the sweeping nature of Bill 26, coupled with its concentration on unilateral decision-making and its startling authorization to breach patient-physician medical confidentiality, has created a charged atmosphere of tension. For people living with HIV, there is a genuine concern about what this bill means in their daily lives. A bill that runs to 211 pages and affects some 40-odd different pieces of legislation is incomprehensible to somebody living with HIV. It's just one more mammoth problem dumped on their backs to figure out and cope with. There is tension all around.

Physicians are unhappy. Labour organizations are unhappy. There is a realistic fear that we may lose physicians and, in particular, that we could genuinely lose much-needed specialists—I think this is a really practical and realistic projection, not a theoretical one at all—who will leave the province because of Bill 26. The natural history of HIV clearly shows that we need dedicated, HIV-aware physicians who are crucial for the people living with this illness, and physician referrals to specialists are vital to managing patient care and providing a minimum quality of life.

The basic social safety and basic health care for people living with HIV appears to be shrinking or becoming more expensive, without viable—

Failure of sound system.

The committee recessed from 1150 to 1153.

The Chair: We've got our power back on, so we can reconvene. Okay, Mr Sobota, you can carry on.

Mr Sobota: Thank you. The basic social safety net and basic health care for people living with HIV appears to be shrinking or becoming more expensive, without viable alternatives being either offered or explained. The fear is real. The insecurity is genuine. This atmosphere of tension is a legacy of Bill 26 that we will live with for a long time, no matter what form you pass it in. We acknowledge that you will pass it. We hope that you will amend it. But there is a legacy already generated of fear and tension and insecurity just by what has already been introduced.

In summary, Bill 26 is legislation that sees Ontario's health care primarily as a financial matter rather than one of people's health. It's driven by (a) provincial cost-cutting and (b) offloading of costs to municipalities and individuals. We don't believe for a second that costs to us as individuals will be less. They may be to your level of government. Municipalities will pick up these costs and charge us more for services. The bill doesn't start from what the needs are; it doesn't even address the subject.

The sweep and the breadth of this legislation is staggering. We've been able only to comment on those few sections we could analyse and understand now in the brief time available to prepare for these hearings. We've not had sufficient time and opportunity to review this bill

in terms of all the implications for people living with HIV. We are raising what stands out for us, but we're genuinely concerned that there are areas that will be missed. We question how this committee can work through all the implications for every issue in so short a time frame.

At its core, Bill 26 is writing a lot of blank cheques and asking us to trust how they will be cashed in. It visibly demonstrates a lack of trust in due process and checks and balances by removing the government from review or penalties should the blank cheques bounce down the road. As a simple but revealing comparison, we would never be allowed to operate in this manner. You wouldn't let us. Bill 26 has engendered a complex world of fear and insecurity within people who do and who don't understand its implications.

We very much hope the government is considering amendments to Bill 26 and that they will be tabled for public review and discussion before passage of the bill is sought. There's a long-standing history of partnership between government and its citizens, between ministries and community groups, that should be taken advantage of. So much is at stake, so many lives are affected.

The Chair: You've left the committee with the challenge of three quick questions, one each. We'll start with the government.

Mrs Johns: I'd like to thank you very much for coming today. We appreciate the presentation. I know you've put a lot of thought into it. Since I only have a quick question, I want to talk about the drug issue. As you know, with HIV especially there are needs for new therapies all the time, and new therapies are being delivered all the time. There's so much pressure to have new drugs available to people with HIV. In order to be able to add new drugs to the ODB program, it must be made more sustainable and affordable. It's grown by a huge percentage in the last 10 years. Can you comment on how you could see us doing that, what the problems are with the drug benefit formulary?

Mr Sobota: To people who have fixed and reduced incomes, it's not an issue for them about whether the drug formulary has increased by 10% or 15% or 20%. These are people who may be facing two or less years of their lives. That's not their concern. Their concern is: "How do I get through next month? The government licenses and says 3TC is going to help me, it will sustain my life, it will give me a quality of life. But it will not pay for it and I can't pay for it." The equivalent of that is, "I'm going to die because of the government's action." It's not their issue about how to make that affordable. It's the government's responsibility to find where that money can come from.

Mr Gravelle: Michael, thank you very much for your presentation. You touched on just a number of areas that I wish we had more time to get into. There just are several, but if I may, I think I'll focus on the whole aspect of voluntary testing in terms of confidentiality of records.

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I know that the AIDS committees across the province and across the country have worked for years on education and awareness to try and get people to understand

and have built up a certain trust. The implications of voluntary testing falling as a result of what's happened already just in terms of what's been proposed in this bill are I think extreme, but if you could just amplify a little more what you think the implications, the worst-case scenario, would be if the amendments are not made in terms of the confidentiality provisions.

Mr Sobota: It is so difficult to draw into the health care system people who are scared and frightened, and people who have HIV or AIDS are scared or frightened for a range of societal stigmatizations. We've worked on that for 10 years and we've had multiple layers of government support to do that for 10 years. If I'm living with HIV and know that I need to access a physician, but I go to that physician and he may be being scrutinized so that they can have their costs reviewed or reduced or eliminated, I'm not even going to come forward. I'm not going to go into the system. I'm going to be scared out of my mind to have what's already a scary thing for me to live with analysed and scrutinized by larger officials and/or then made public.

Ms Lankin: Let me say on behalf of all former Health ministers and, I truly believe, the current Health minister, how much we thank you for your past and your ongoing work, things like anonymous testing and treatment guidelines and treatment standards and the Trillium drug program. You and others you've worked with have really brought about those changes in this province and we lead in many policy areas as a result of that work.

There's so much I want to ask you and can't. You've covered a lot in your presentation. Some of it we've had a chance to talk to people from other communities' AIDS committees about, so I'll leave that.

There are two things I want to ask you to expand upon. We have not before heard the concern about a provision in the other section of the bill of municipalities' ability to do away with local boards and local boards of health. I'd like to hear about that. Secondly, on the independent health facilities option of opening up for for-profit American firms, do you have any knowledge of, in the United States, what kind of treatment HIV/AIDS patients receive under HMOs in the private sector delivery of service that would be of interest to us to know?

Mr Sobota: The first piece: I was astonished when it was drawn to my attention—I believe it's under schedule M—that municipalities will be given the power to alter their arrangements with local boards of health or dissolve boards of health. I couldn't believe that authority was going to be given to city councillors, and the linkage here is again economic. The linkage is about funding, because there's a statutory relationship between municipal councils funding a portion of the operating budget for boards of health.

You'd better believe that municipalities won't increase that relationship. So what they're likely to do is decrease it or, if they don't want to do it any more, simply absolve themselves of the responsibility to carry that portion of those budgets.

The Chair: Unfortunately, I'm going to have to cut you off. We've used up all the time. The question was just a little bit too long.

Ms Lankin: That was a short question.

The Chair: I realize that, but everybody was asked to have a short question.

Ms Lankin: I'm beginning to think that every time I mention for-profit American HMOs, you get a little touchy. There's a pattern here.

The Chair: I just think we've got a challenge with 15 minutes for lunch and checking out. We need to keep on schedule.

Thank you very much, sir. We appreciate your involvement in our process.

THUNDER BAY MEDICAL SOCIETY

The Chair: The last group this morning is the Thunder Bay Medical Society, represented by Dr Milne, Dr Fernandes, Dr Stamler and Dr Kutcher. Welcome to our committee. We appreciate your being here. You've got a half-hour of our time. Questions, should you leave any time for them, would begin with the Liberals. The floor is yours.

Dr Gordon Milne: Good afternoon. I'm Gordon Milne, a general practitioner in the city of Thunder Bay. I'm president of the Thunder Bay Medical Society, a delegate to council of the OMA, chairman of the ethics committee of the medical association and long-term care representative on the Thunder Bay Regional Hospital MAC.

My co-presenters today are Dr Walter Kutcher, a gastroenterologist in the city of Thunder Bay; Dr John Fernandes, an obstetrician-gynaecologist in the city; and Dr Jim Stamler, president of the medical staff and a member of the executive of the board of the regional hospital. Dr Kutcher is the vice-president of the medical staff and a representative on the board of the regional hospital.

You'll also meet three of our general practitioners, and I thank the Chairman for allowing them to give a short presentation on how we see problems arising from the act, if passed in its present state. I'd like to thank the committee for hearing our concerns and also thank those who helped ensure that our concerns were heard today.

Those present represent both the 263 physician members of our society and also physicians who are not members of our society. Our city's physicians are widely represented on boards and advisory councils and are active in sports, cultural and community activities. Hospital reorganization has been actively supported by physicians through their participation in the hospital planning council, the one hospital committee and latterly in the amalgamation of medical staff of all acute care hospitals in the city.

We, as Ontario physicians, have great concerns regarding the implications that the proposed changes will have on health care across the province. We are particularly concerned regarding the effects that the proposals will have on the availability of health care in our city, our district and the region. We're also concerned that statements by the Health minister show a lack of understanding of health care processes.

While all physicians practising in Ontario are members of the OMA, some physicians would prefer to be represented in government discussions by other groups. We,

however, feel that health care can only be provided with input from physicians and that the government must hear the concerns presented by an organization or organizations approved by the province's doctors.

Now we'd like to give a short presentation of about 10 to 15 minutes by the three family physicians who are here today: Dr Martha Stong, Dr Pam Johnson and Dr Janet McLeod, who are better known as the Buck Stops Here Family Practice Group.

The Chair: This part of the presentation is not on the record.

Mrs McLeod: On a point of order, Mr Chair: May I ask why?

The Chair: Because they're not at microphones.

Interjections.

The Chair: Excuse me. I don't want to turn this into a charade. The protocol is that we—

Mr Miclash: It's their time.

The Chair: Mr Miclash, we have four people making a presentation. I told them ahead of time this would not be on the record. They agreed to that.

A skit was performed.

1218

Dr Milne: Dr John Fernandes would now like to give a short presentation.

Dr John Fernandes: I want to address the committee's attention directly to the state of obstetrical services, particularly as it relates here in northwestern Ontario.

I'd like to remind you that in the past few years, with the number of family doctors leaving smaller communities in the peripheral areas around Thunder Bay, it is not uncommon for me to see in my office, on a daily basis, women who have driven four hours in to see me in my office for routine prenatal care and who will be driving four hours home. If you think driving on northern roads is an easy process, I've got news. I've had, as recently as two weeks ago, one of my pregnant obstetrical patients, at 28 weeks, end up in a ditch in an overturned truck. This is not exactly easy access to health care here in northwestern Ontario.

In Thunder Bay itself, between our two hospitals, we do approximately 2,000 deliveries. We are eight obstetricians servicing everywhere from Wawa basically to the Manitoba border. As a result, our offices are quite replete with patients. We're very busy, working very hard in order to keep up with the pace. The 2,000 deliveries that we do locally are not just divided, fortunately, between the eight obstetricians. About 1,200 of those deliveries are actually performed by obstetricians here.

If you divide that 1,200 by eight, you will come up with the number of 150. If the current legislation goes through as it stands, it would mean that those 150 deliveries physically performed by each individual obstetrician will not be remunerated to that obstetrician whatsoever, because all of the income from those 150 deliveries will go towards paying malpractice premiums in order to just perform the service. As a result, I am anticipating—and we have had discussions about this—that if this bill goes through as it stands, without any adjustment for this malpractice situation, I fully expect that you will be having eight obstetricians resign their obstetrical privileges very shortly.

We have been told by CMPA and by the college that should we not have obstetrical coverage with malpractice premiums, given that situation, should we, in an emergency, perform any obstetrical procedure, we will not be covered, and in fact the college will come down hard on us. As a result, there will be no obstetrical coverage from a specialty point of view in northwestern Ontario. All 2,000 deliveries as a result will have to head to southern Ontario. I hope that somewhere the government is willing to and expecting to be able to fund that transport of 2,000 patients a year down to southern Ontario for delivery. From a very practical point of view, that's what we're facing.

The situation that is going to also develop in the area of orthopaedic surgery will be the same. With orthopaedic malpractice premiums increasing at the rate at which they are currently increasing, also up to the equivalent of what obstetricians are performing, with our shortage of the current number of orthopaedic surgeons in town here, I fully expect that we are going to start to see an exodus of physicians from this part of the province. From a purely economic point of view, you can't afford to continue to practise where all of the income is going towards paying the premiums just to be able to practise. It's not practical.

In the long term, our concerns are that with all of the changes that are being proposed with this, it is going to make obstetrics and gynaecology a very unattractive area for physicians to enter into in the early stages of their careers, when they're making career choices. As a result, our residency programs are going to fall apart, the educational aspect in obstetrics and gynaecology and any research that is currently going on will eventually come to a halt and women's health care issues are going to be ignored once again. It's taken years and years to get women's health care issues recognized and attention being drawn by various governments; to do this at this point would be an enormous step backwards, and I suspect a detrimental one not only to women's health but also to children's health in this province.

Afterwards, I'd be quite willing to answer any questions specifically around obstetrics and gynaecology in this region.

Dr Milne: Dr Kutcher will now give his presentation.

Dr Walter Kutcher: I've enclosed a handout of things I wanted to cover, so I'm going to briefly highlight a few points.

I fear that the adoption of this bill may hamper our ability to provide quality medical care to patients in northwestern Ontario. Allow me to outline several areas of concern to me. I'm going to skip number (1), because I think timewise we're running a little long. I'll leave that for you to read, if you wish.

(2) Under schedule H, new physician billing numbers will only be issued in undersupplied regions of the province, and doctors will not be allowed to move within the province without ministry approval. I applaud the government's stated desire to address the shortage of physicians in underserved areas of the province. The estimates I have read suggest that 200 to 400 doctors are required to fill these important spots.

Several areas are of critical importance to us in Thunder Bay and northwestern Ontario. For example, at present we have no tertiary trauma service because of our shortage of orthopaedic surgeons and neurosurgeons. I don't believe that Bill 26 will force these types of physicians to underserved areas. Furthermore, the ones it does force here may not be the physicians who are best for our patient care. I believe it's the wrong approach to take. For instance, when I came to Thunder Bay six years ago, I planned it to be for a couple of years. However, my family and I have found we like it here and plan to stay. If six years ago I didn't have the later option of moving in Ontario, then I would have opted for a job in the United States.

I believe that doctors should be enticed to underserved areas with incentives. Incidentally, the incentive hasn't changed since 1980, I believe. Some will choose, as I have, to stay in these areas. This surely provides better-quality medicine to our patients than we would expect to have by forcing doctors to work here against their wishes. Furthermore, specialists such as orthopaedic surgeons and neurosurgeons, who are still in great demand in the United States, will surely move there rather than to Thunder Bay.

I also believe there are other ways to limit physician numbers in overserved regions of the province. This could include differential billing fees for new physicians in the areas, alternatives to fee-for-service practice, a limitation on the number of medical school graduates and foreign doctors as well.

(3) Schedule H also gives the general manager of OHIP powers to unilaterally reduce or refuse to pay claims and may require a physician to repay the plan for services deemed not medically necessary. Inspectors will be given wide new powers of inspection and entry for examining patient and physician records.

I understand the government's need to make the health care system more efficient and effective. I also believe that almost all doctors are fair and honest. I don't believe the government should have the right to decide whether a particular service I require for my patients is medically necessary, and further have the right to penalize me without the right of appeal. If physicians begin to second-guess their clinical skills, patient care will suffer due to inadequate diagnostic testing and care. Furthermore, the potential for confidential patient information being disclosed may also result in poor care, as patients may choose not to report information about abortions, drug history, psychiatric history etc, in the fear that it could be disclosed at a later date.

If the true reason for these powers is to catch the few Ontario doctors who may act fraudulently or refer excessively, this can be done by expanding the powers and penalties already in place by the College of Physicians and Surgeons of Ontario Medical Review Committee. This desire to reduce fraud will come with a huge cost both for the freedom of our medical profession and potentially the care we can now give to our patients.

(4) This has been covered by Dr Fernandes.

(5) Schedule I also cancels all agreements between the government and the Ontario Medical Association. This will make it impossible to establish new health care

initiatives, such as the proposed nursing station in Armstrong, Ontario, a northern Ontario community near us which traditionally has had great difficulty in providing adequate medical care to that region.

In summary, as a concerned citizen of Ontario, I appreciate the need to get Ontario out from under its crushing deficit and debt load. I understand this will require a fundamental restructuring and rethinking of public services as part of balancing our provincial budget. However, I believe Bill 26 is an unnecessary intrusion into the workings of the medical system that will have adverse consequences both for our profession and, most importantly, for our patients. I believe the needed changes can be achieved using the mechanisms already in place, with the continued partnership between government and local institutions. At best, the bill should be delayed several years to allow the local solutions to occur. At worst, as it applies to health care, it should be scrapped. If this bill is enacted and the powers in it utilized, I predict that in several years we will look back and see that it really created quite a mess.

Thank you for the chance to speak.

Dr Milne: Thank you for your attention. We would be happy to entertain questions.

The Chair: We've got just basically a minute each, time for one quick question each, beginning with the Liberals. We have to get on with that other debate, so we'll limit it to the minute.

Mrs McLeod: Yes, indeed. I would have asked what the effect of Bill 26 would be on your patients. You've already demonstrated that, I think, very effectively in just for the record reiterating the fact—and I'm going to do this in less than a minute—that there is no appeal from a revoking of a physician's privileges. You could have gone on to quote section 26 of the same schedule, which would say the general manager of OHIP decides who is an eligible physician, and there is no appeal of that decision either.

You also indicated that there can be a refusal to pay for a referral to a specialist if it was considered not medically necessary. There is at least some form of physician review of that, but if there is a decision by the general manager of OHIP or the minister that what you did as a physician was not medically necessary, you can be denied payment for that service, and that would have to be referred by the physician himself to get any kind of appeal of that.

The third one you were pointing out was that virtually everything else in Bill 26 gets in the way of a patient's relationship with the physician. I would specifically ask you perhaps to address the fact that it's new and significant in this bill that it gives the government the power to decide what is medically necessary.

The Chair: Thank you, Mrs McLeod. Ms Lankin.

Ms Lankin: Thank you very much. You've covered a wide range of areas.

I want to ask you a question about the proposed billing number restrictions. We heard yesterday that not only new physicians but existing physicians who realize that if this bill becomes law their billing number might be frozen in this area, even though they've been here and they are committed to practising here, because they can't

see into the future, what might happen with them is that they might leave and establish southern practices now, before this comes into effect, and that in spite of the OMA having now put an offer on the table to pay for the incentives out of the physician pool and all those other solutions that the government says it's going to give a chance to let happen, we may not have an opportunity to see the benefit of because doctors might leave in advance.

I want to know: Is that an empty threat?

1230

Dr Milne: We've already had one emergency physician leave town this week to move to southern Ontario to make sure he can get a licence in southern Ontario. We have just been told this in the last two weeks, that we're losing a urologist and a nephrologist.

The Chair: Thank you, doctor. For the government, Mr Clement.

Mr Clement: Thank you for your presentations and for the graphic demonstration of your point of view. You gave us a lot to think about and I appreciate the time that you've put into all aspects of your presentation.

In the limited time I have, I just wanted to turn to the definition of "medically or therapeutically necessary" and who gets to decide. Do you think that there is a way, from your perspective, to improve the unconscionable wait that sometimes occurs with the Medical Review Committee to improve that committee, to make it do the job that it's supposed to do on behalf of the taxpayer, and not overturn that balance in favour of the bureaucracy? Is that something that you're willing to work towards?

Dr Jim Stamler: I think definitely there's a wide body of knowledge across the border, and insurance companies are using this knowledge regularly in the private industry. In fact, physicians are human and what they need is guidelines to practise. If it's defined what we need to do for our patients, we can look at what the patient needs, make individual decisions, and there are probably some areas that at this point may not be necessary. It may be deemed for society's good that we should not be doing these things. But we're human beings and we need to know that we are following a set of guidelines that will help the patient and make us feel better as we do it. If we feel like we're frauds every time we do something, you're going to get some really strange behaviours coming out of doctors.

The Chair: Thank you very much, doctors. We appreciate your presentation here today.

Mrs McLeod: On a point of information, Mr Chair: Yet another of the groups that had hoped to make a presentation today was the Thunder Bay Pharmacists' Association, and they have provided a written brief. I appreciate that being tabled for all members of the committee, but I did want people who are attending to know that the pharmacists have also made representation.

The Chair: Just a couple of points: we have to check out by 1 o'clock, and the 3:30 pm pickup for MPPs.

Mrs McLeod: Is it also appropriate to recommend and perhaps to move that we allow for a half-hour break at lunch? We are only 10 minutes from the airport and it is not snowing, and I do think that, given the power of interruption, we could afford to take a reasonable break

of 20 minutes or 25 minutes for lunch and still get to the airport on time.

Mr Clement: We'll be finished by 3.

The Chair: Yes, that's all we have. Out of respect for the people who came to present, we're going to stick to the schedule. We're going to deal with Ms Lankin's motion.

Interruption.

The Chair: We still have some unfinished business. If you wish to stay you're welcome to, but we need to be able to hear.

Ms Lankin: Just to let people know what is happening, we're debating a motion which would have this committee recommend to the government House leader that we consider coming back to Thunder Bay to be able to hear from those people who didn't get a chance to get on before this committee today.

Mr Chair, I know the committee members know my very strong feelings on this issue. We went through some raucous times in our relationship in the Legislature and in the end determined, collectively among the three parties, a process that we would adhere to which included three weeks of public hearings, but for the opposition gained us the very important aspect of being able to travel outside of Toronto to hear from people.

None of us at that time knew the overwhelming public response that we would receive. While there is some dispute around the numbers and how groups are counted, no one can dispute that in the two weeks we're out travelling right now, the two committees, there are over 1,000 groups or individuals who have applied for somewhere just under 300 available spots. The number that I have been given is 274 available spots. The government disputes that and thinks it's closer to 300. I don't care. That is still astounding: over 1,000 people for just under 300 available spots.

Here in Thunder Bay, even with the accommodation to get on an extra group that we've just heard—and I'm glad we heard from them—there are three times as many people who have applied as there are spots available. Only one third of the people or groups who've applied to be heard by this committee have been able to be heard.

I have to say that we know that it's up to the group if they want to leave time for questioning, but there's such in-depth information and the breadth of the bill that people want to be able to comment on and the opportunity for dialogue and to be able to pursue some of those things would only improve the legislative process. I'm sorry we didn't get a chance to have a full discussion with some of the participants today, and it's not their fault. You can't physically address all of the areas of concern in the bill to many of the groups or organizations or individuals in half an hour and still have time for questions.

There are many groups who are not even being heard. I appreciate the written submissions, but I want to be very honest with people. I think I'm a very conscientious, hard worker, but I am sitting on committee from morning to evening, leaving, getting on planes, going to the next community. I have a meeting all day Saturday to try to go through developing amendments that we're going to be tabling the following Monday. I travel all next week,

I come back, I go into clause-by-clause analysis, and I want to be honest with you, although I will try, I know I will not be able to read all of the written submissions that people are being encouraged to apply. So I feel sorry that people are being led down a garden path, that they think this committee—and I challenge anyone on this committee to tell me that they will be able to read every word of all of those submissions.

All I'm asking the government members is to please recommend that the government House leader look at this issue again, look at passing the things that they need to pass on the 29th, but let us deal with some of the longer-term, bigger policy areas that are not necessary for your immediate fiscal agenda. Please, just make this recommendation from the committee. Let the House leader make the decision, but let's have this committee at least acknowledge the number of times you heard today in Thunder Bay people saying they needed more time and they wanted more people to be heard and that the bill should be dealt with in a different way.

The Chair: For the government, Mr Clement.

Mr Clement: I will speak against the motion. I feel that the premise of the mover of the motion is flawed. The process that we have undergone has been a worthwhile, extensive process. We have had a diversity of points of view in Thunder Bay this morning so far—we haven't even got into the afternoon yet—where a lot of different points of view have been able to be expressed, many of which have been critical of the government's position on either the entire bill or specific portions of the bill. Where people are unhappy, they have been given an opportunity to suggest amendments. We are listening to those amendments, at least on the government side. I can't speak for the other side. I'm sure they are too.

Mr Pouliot: Come on. You're lying through your teeth. Be fair.

The Chair: Mr Pouliot.

Mr Clement: I'm sorry Mr Pouliot feels so strongly about this, but I can assure him that I am listening very closely to the presenters in Thunder Bay, as in the other cities that we have been to. In fact, both sides of this committee, the health and the non-health side, will have had 750 slots, by my personal calculation, for presenters to express their views. I think that will provide for the diversity and multiplicity of opinion and views held by people in all corners of Ontario. So I think it's a fair process that is giving good input, and I guess I disagree with the mover's premise from that point of view.

Ultimately, the job, the obligation of legislators, is to have a period of time where we consult with both our own constituents but also with the wider public, and then ultimately to act. We must act as legislators. We must legislate. That period was agreed to by all three House leaders—NDP, Liberal and PC—to be on Monday, January 29, 1996, and I am sticking to that agreement.

I must put on the record yet again that this bill is receiving more time in committee than any bill in the previous two parliaments—in the previous two parliaments. Even extending the hearings—

Ms Lankin: That's not true. That's incorrect.

The Chair: Excuse me, Mr Clement has the floor.

Ms Lankin: That's factually incorrect, though.

Mr Clement: I put it to you that that is in fact true. I've said it on many other occasions and you have not objected.

Let me add this one point: We heard from deputations today and yesterday about the need to proceed with restructuring, the need to get on with the job, to re-allocate some of the resources into areas where perhaps we are spending without regard to whether it is money well spent and to put it into areas such as HIV, such as long-term care and such as community-based health which genuinely need the funding. The only way we can get from here to there, the only way, is to move ahead with the legislation. If we hold off for yet another month, that will cost, by my calculations, at \$1 million an hour, \$720 million going to the interest on the debt rather than to our hospitals, rather than to our community health centres, rather than to our HIV patients. I think that is unconscionable. I will not let it happen. I will vote against this motion.

The Chair: Mr Pouliot, just as a point of order, I believe I heard you say something that is rather against the rules, and I would ask you to withdraw that.

Mr Pouliot: If I mentioned in a fit of passion that a member opposite was lying through his teeth, I will withdraw this and substitute it by saying that he was shying away from the truth.

Mr Gravelle: If there's one thing that's become clear, and I think Mr Clement knows this, as he brings out the argument that indeed it's costing \$1 million or whatever amount it is in terms of interest payments, the fact is he knows full well that extension of the hearings—

Interjection.

Mr Gravelle: Whatever figure they keep using. The extension of the hearings is clearly what is needed. The fact is that by allowing the public to have real input—I've been sitting in my constituency office this past week talking to people who were not able to get on to this committee list who want very much to make presentations, and he admitted earlier that it is indeed one of the responsibilities of the legislative process to have committees go forward. There is absolutely no truth to the fact that extending the hearings—allowing people to have more input into February would not by any means change the process in terms of the debt. Things can still be put forward. Things can still be passed. You know it's true.

The fact is that hearings are what people want and need. I think it's the height of arrogance to say that there's no time for more hearings when indeed throughout whatever community you've gone to and certainly Thunder Bay is one of those communities, there are a variety of groups who very much have a great deal to add to the possible list of amendments that need to go for this bill, and I think it's clear that certainly we in the loyal opposition support Ms Lankin's motion and find it astonishing that the government cannot at least bring forward, as you did say when you were speaking just now—if there are some things that have to go forward on the 29th, fair game, let's talk about it with the three House leaders. We would be willing to talk about those options, but give the people of Ontario and the people in Thunder Bay a greater opportunity to make their points

of view about this bill, which is mind-boggling and frightening to a lot of people.

We completely support the motion.

The Chair: One minute to sum up.

Ms Lankin: A very quick wrapup: Mr Clement, you heard many concerns raised today and many of the issues, in fact in the last presentation—let's just take that—they raised that you know when that bill's passed on the 29th, on January 30, not one cent is going to be saved against the deficit, and your numbers of \$720 million in a month is like the deficit will be eradicated by this budget bill. That is so misleading.

The other thing I want to say is, you said you're here and you're listening to people. All the way through the Toronto hearings and many of the presenters in the last three days in northern Ontario have said, "Break this bill up and slow down some of the bigger pieces." If you're listening, why aren't you prepared to pass on that recommendation to the House leaders and let the House leaders figure it out? You don't need to stand in the way of that. Let the House leaders figure it out.

The Chair: It's time to vote on the motion.

Ms Lankin: A recorded vote, please.

The Chair: Ms Lankin has requested a recorded vote. Those in favour of Ms Lankin's motion?

Ayes

Lankin.

The Chair: Those opposed?

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated three to one.

We'll recess for 15 minutes.

The committee recessed from 1244 to 1303.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1409

The Chair: Our first presenters this afternoon are from the Lakehead and District Council of the Canadian Union of Public Employees: Jules Tupker, Alan Black, Darrel Williams, Lois Vanson and Connie Leblanc. We'll beg your indulgence. We didn't have time for lunch, so some of us may be grabbing a sandwich as we're going through here, but we're still paying attention. The floor is yours. You have a half-hour. Questions, if you leave time for them, would begin with the government.

Mr Jules Tupker: My name is Jules Tupker. I'm the national representative for the Canadian Union of Public Employees. I represent bargaining units in Thunder Bay, Atikokan and Fort Frances, hospital locals, homes for the aged locals, municipal and so on. The original seating was for the district council. A number of the executive are in Fort Frances and they were unable to make it today so we've asked Local 1409 to sit in on the hearing. I'll just go through my presentation for you.

The Savings and Restructuring Act, Bill 26, is one of the most devastating pieces of legislation ever brought forward by any government. This bill, disguised as a money-saving venture for all of Ontario's citizens, is

going to lead to unprecedented hardships for all the citizens of Ontario who are least able to fight back—the sick, elderly, poor, disabled and unemployed.

The implementation of Bill 26 is a major step for the Harris government towards the creation of a totalitarian state. As extreme and bizarre as this statement may sound, anyone who takes the time to look into what powers Bill 26 takes away from the citizens of Ontario and gives to a few power brokers in the government soon realizes the seriousness of the situation.

Today we are here to look at the effect Bill 26 will have on health care. The changes contemplated in the bill will give the Minister of Health unrestricted authority to enact changes to the delivery of health care that will be catastrophic to not only health care workers, but to any citizen who relies on publicly funded health care and who could never afford to pay for the care they need. These changes will lead to the Americanization of our health care at a time when Americans are trying to Canadianize their health care.

The health care system in Ontario is indeed in need of reform. No one wants to see the debt of this province continue to rise. However, the massive cuts and control measures that are proposed in Bill 26 will do much more harm to far more people than any savings derived from Bill 26 can justify.

Schedule F of the bill amends the Ministry of Health Act, the Public Hospitals Act, the Private Hospitals Act and the Independent Health Facilities Act, resulting in changes in many areas.

Bill 26 will give the Minister of Health virtually unlimited authority in respect to the funding, operation, amalgamation and closure of public hospitals. The minister can ignore the needs and desires of a local community in the operation of its hospital and the minister has the power to close hospitals simply for financial reasons. The current Public Hospitals Act does not allow the ministry to stop funding for budgetary reasons without taking into account the effect the closure will have on patient care.

The effect that this power will have on northern Ontario's remote communities with their small hospitals could be devastating. Patients could be forced to drive hundreds of kilometres in severe weather conditions to receive basic health care, and, I might add, on highways that we feel will probably be maintained at a lower level than they presently are.

Schedule F of the bill also provides the Minister of Health and the cabinet with protection from any legal liability with respect to any direction issued to a hospital and with respect to the effect of any funding decision. The minister and cabinet will have been placed above the law.

Changes to the Independent Health Facilities Act will eliminate the tendering process and will also eliminate the requirement that any preference in the tendering of services be given to non-profit Canadian operators.

The minister will be able to handpick companies and individuals that follow his wishes in regard to health care. The minister under Bill 26 even has the power to prevent physicians presently providing services from continuing to do so.

These changes open the door to private companies determined to make a profit. Undoubtedly, these companies will be large, multinational organizations that have no interest in preserving Canada's health care system.

The loss of confidentiality of personal medical information also becomes a reality under this bill. The minister will be allowed to collect, use or disclose personal medical information for any purpose he or she feels is necessary.

Schedule G of Bill 26 will introduce the citizens of Ontario to a user fee for prescription drugs. Also, a \$100 deductible charge will be implemented. These charges may seem insignificant to us, but to the poor, disabled and seniors, all trying to survive on fixed incomes, these fees will be devastating and will in some cases restrict the ability of these people to obtain the drugs necessary for their wellbeing.

The deregulation of drug prices for drugs not covered by the Ontario drug benefit plan that Bill 26 allows will encourage drug companies to increase the price of drugs substantially. Under schedule G of the bill the minister's power to regulate the price of drugs will be removed. This change will be significant in northern Ontario, where the remoteness of communities will surely result in significant increases in drug prices.

The removal of public input into the setting of drug prices and the determining of issues under the Ontario drug benefit flies in the face of two court rulings that went against past government decisions. The government is in fact putting itself above the law by enacting this section.

Bill 26 under schedule H will authorize cabinet to implement user fees for any hospital-based insured services including those covered under OHIP. The government has already announced that daily user fees for patients in acute care beds awaiting placement in chronic care facilities or nursing homes will be implemented. Patients placed on waiting lists for critically underfunded facilities will be penalized while they wait for placement.

The Health Services Act that is in effect now requires that OHIP cover all medically necessary services provided by physicians. Bill 26 removes any references to medically necessary services and authorizes the cabinet to decide which medical services will be insured and under what conditions and limitations. Further, cabinet is also given the power to determine that certain services will not be treated as insured services unless they are provided in or by designated hospitals. These powers could have serious implications in northern Ontario where remote hospitals can be told what services will be covered in a particular hospital, and patients requiring treatment in a community hospital not covered under OHIP will be forced to travel great distances to another hospital.

In conclusion, the changes to hospital and health care services proposed in Bill 26 will seriously damage if not destroy the publicly funded medicare system that is in place today. The passage of this bill will result in a decline of health care that is absolutely unacceptable to the citizens of Ontario and a decline that the Conservative Party and Mike Harris promised the people of Ontario would never take place.

Bill 26 will encourage the privatization and corporatization of health care, which will result ultimately not in cost savings but in ever-increasing costs to the citizens of Ontario. Reform of Ontario's health care system is necessary, but it is essential that any reforms that are enacted do not lead to the destruction of a health care system that is the envy of the world. Bill 26 will destroy that system and that cannot be allowed to happen. Bill 26 must be withdrawn.

1310

The Chair: That leaves about six and a half or seven minutes per party for questions, beginning with the government.

Mrs Ecker: Thank you very much for coming forward today and taking the time to bring forward a presentation with suggestions for Bill 26.

One of the things I just wanted to clarify, if you will, is that as far as I know, Bill 26 doesn't remove references to "medically necessary." I think that's something that is very important in terms of the judgments that have to be made and allowing physicians to make those decisions. That is something in there, in the process, and I think we will make sure it stays in the process because I think that's a fundamental principle.

Secondly, the Canada Health Act is very clear in terms of what we can and can't charge for insured services, and certainly the province is not planning on violating the Canada Health Act. That is something I'd like to assure you of, because that is, as you point out, a very important factor.

The other point that I think is worth making about independent health facilities is that the Independent Health Facilities Act, which is a regulatory act and is designed to promote quality assurance within licensed facilities—and there has been a serious problem over the years with many facilities providing various kinds of medical care that do not come under that legislation.

There have been serious questions raised by physicians who practise there, patients who receive care there, about the quality of care in those facilities. As a matter of fact, there is one famous death of a patient in one facility where the coroner, as I recall, was recommending that something be done about that.

One of the things I think it's important to remember is that anything that is licensed under the Independent Health Facilities Act, regardless of the ownership, regardless of whether it's profit or non-profit, it's important to point out that there are for-profit IHFs out there now, so they're already there. Quality is the main thing about that legislation, so I think that, regardless of who's there, that is there for the protection of the public.

You mentioned about Bill 26 taking away the public process for setting of drug prices, and I'm not clear what you mean by that.

Mr Tupker: When I read the act, I read that to say the government is going to be able to set the prices for the drugs, and there's not going to be any input. In other words, there's going to be undue influence put on the government by corporations in drug prices, and that's going to be a problem.

Mrs Ecker: I think what I read, and I just want to clarify it, was that there was some public process for

setting drug prices that was being removed by Bill 26, and I just wasn't clear what you meant by that.

Mr Tupker: There's not a public per se input into that, but all drug prices are controlled by the government and we feel that the bill will change that. The private corporations will have more input into the establishing of drug prices. That's going to be a problem. Obviously they're in the business to make a profit and we feel that any input that the public or public institutions have in establishing prices should be maintained.

Mrs Ecker: I think the government, as one of the biggest customers of drug companies, has much clout. I would line up against some of the drug companies any day on this.

One of the things we've talked about is the attempt to try and restructure the health care system. We've heard people come forward from all across the system who said we need to restructure the system. We've also heard people say that there is a need for an authority, a power—whether it's the minister or a hospital restructuring commission is a point that some people disagreed on—but there is a need for something to do that restructuring, to make that happen. Do you have any response on that? Do you think that's a good thing or a bad thing? How would you advise the government to do the restructuring that the experts in the field say needs to be done?

Mr Tupker: That's an interesting question. As I said in the report, we understand that there has to be reform. There's no doubt that we can't go on the way it's been going. The fear we have in this bill is that it's going to be done by a small group of individuals within the government, and the smaller group of individuals you have, the more influence large corporations are going to have on those individuals.

We see this bill as taking the power away from the larger government body and instilling it into a smaller group, and that group will be influenced by private sector organizations and corporations and public influence will deteriorate under this bill. That's what we're concerned about. I guess time will tell whether decisions made under this bill are correct. We just see it heading in a direction we don't like, and that's why we're opposed to it.

As to what changes we'd like to see, again I'm not an expert in the health field, but I'd like to see experts from all walks of life help to establish a plan that would see reform in health care that would be fair to all people. At this point, we feel the changes are going to affect the people who are least able to defend themselves. Canada is premised on helping each other, and we feel this bill is going to take that opportunity away. People will be hurt by this bill.

Mr Gravelle: Thank you for your presentation. Obviously, there's a number of areas I'd like to ask you about, but the aspect that concerns most people is the sweeping powers the bill gives the minister, and you've made some reference to that in terms of making it into a small number of people who have some control. One of the overall aspects of Bill 26 is that it essentially removes the ability of the legislative system to be part of it and moves everything into regulations. You look at the bill in various aspects and find that the minister has the final say and in fact the crown is not liable for anything.

I presume you see that as a concern in the health areas, but I wonder if you've looked at other aspects of the bill and have the same concerns, the fact that the minister will have final authority, the fact that ministers and the crown will not be held responsible for some of the actions they take.

Mr Tupker: You're absolutely right. Government is elected by the people, and what we see here is that this bill is just taking power away from the people and concentrating it into a small group. The whole Legislature, the people we elected, are going to have very little say in any action this government takes, and that's not acceptable to us.

Mr Gravelle: I asked a question earlier of another presenter about awareness of the bill by the people they serve. One thing we've discovered is that because of the short time frame and the complexity of the bill, there is not yet the awareness of what's in the bill and how it's going to affect people. I think there is a gathering awareness, and that's why we've asked for more time to have more public hearings, so that people have an opportunity to look at it more closely.

I presume your membership was keen to have you come forward and make a presentation, and I suspect they'd want you to do so on the other aspects of the bill as well. What is the awareness level of your membership? How large is your membership?

Mr Tupker: Local 1409 at McKellar hospital has only about 90 members. In the health care field in north-western Ontario, there are probably a few hundred in CUPE. We're not a great, large group.

In terms of awareness, these four people on the union executive who are here don't know what's happening. It's as simple as that. They're not aware of what this bill entails; they haven't seen a copy of it. I have it in my briefcase, but I haven't had a chance to go through the whole package. I pick out highlights, and we've had legal people give us the highlights and try to pick out some things. The vastness is just phenomenal. The powers it gives the minister and a few people are unbelievable, but the membership knows nothing of what's going on. I know, because I've spent some time reading the document, but to ram this thing through in the matter of a month is just phenomenal, absolutely unheard-of, and it should not happen.

Mr Gravelle: That really is one of the points we want to make so strongly. Your union is terribly interested in what implications it has for you as employees, obviously, but at the same time, with the complexity, it's very difficult to be able to get into it. We're discovering new aspects every day that people aren't familiar with in terms of the powers in it. If there were anything you could say or do, besides what you've got in your presentation, one piece you would want to have taken out, one element, what would that be? The bill appears to be going through in some form.

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Mr Tupker: I don't think I could name one element. The immunity from the law is a scary situation. They're putting themselves above the law in a couple of areas. The invasion of privacy is very scary. I deal fairly regularly with invasion of privacy: employers trying to

find out medical information about my members. It's totally unacceptable that this bill takes that privacy away. A number of issues in here are of very serious concern to my members and to me.

The seriousness of the whole process is that there's just no time to discuss it. There's no input from the members, from my members of Parliament, to have an opportunity to oppose this bill that's been introduced. We're going through this process now for a month, and from what I understand, it's going to be passed at the end of the month. It's absolutely ludicrous. This is supposed to be a democracy where issues are discussed and debated openly in Parliament. It's not being done here. We're given an opportunity here to the best of our ability to put our opposition forward, but there's just not enough time to present a proper opposition to this whole package. That's a major concern.

Ms Lankin: I appreciate your presentation and all of you being here today. Your last comment that there hasn't been the time to do the full analysis and to consult with your membership is something we have heard from other groups and organizations. Earlier this week it was a group of seniors who, on behalf of the seniors' co-op, came in and said, "But we haven't talked to our membership yet about this." Yet if you were here before the break, you would have heard Mr Clement say: "There's nothing wrong with the process. The process is fine. We've got lots of presentations, lots of time." It makes you wonder if they're listening to your comments about the bill, if they're not listening to the comments about the process and how prepared people are.

I just wanted to make one comment. Ms Ecker said the government will be the biggest purchaser of drugs and therefore will be able to get a good deal. What she didn't comment on from your presentation was the deregulation of prices that's going to affect everyone else outside the government plan, and that's you and I as consumers and our insurance plans etc. That's what's being deregulated. You were talking about the government, being the representative of public input into that process, being gone.

I wanted to spend most of my time with you talking about the problems and concerns you raised around the development of a two-tier health care system and concerns about violations of the Canada Health Act.

Ms Ecker said that the brand-new provision in this bill which allows the government to prescribe certain insured hospital services for which there could be a copayment or a user fee—that they won't do that in any way that would violate the Canada Health Act. But I can point to several places in the old legislation where any regulation power the government gave itself had a condition on it right in the legislation that it had to be in accordance with the Canada Health Act. This new provision they've put in is absent that condition.

Let me give you one other example. In the old Health Care Accessibility Act, in the regulation-making powers under section 45, there was a provision for some services to be prescribed by age. For example, breast screening programs are generally available to women over the age of 55. So that happened, but again it was in a section that had a condition on it that it has to be in accordance with the Canada Health Act. They've taken out that

section of prescribing by age and put it in another section of the act where it now has no protection of the condition "under the Canada Health Act."

Minister Eves went to Ottawa, met with finance ministers and said, "What we want is some flexibility under the Canada Health Act." When you put that all together, I think you've got something when you raise these concerns. Could you comment on what gave rise to these concerns for you in reading the bill and where you think it might take us?

Mr Tupker: Yes, I can comment. Where it's leading us is to an Americanization of health care. It's going to lead to a health care system that only rich people can afford. It's taking away the whole concept of medicare, of equal opportunity for health care for any citizen in the country, in the province. Only the rich can afford it; only the people who can afford to pay for medically necessary procedures are going to be able to have those procedures. It defies imagination that Canada is moving in this direction. That Ontario is leading Canada in moving in this direction is totally obscene.

Ms Lankin: We are asking the government to make amendments in those areas to put the protection of the Canada Health Act back in. We'll see what happens with that.

Another area we're asking for amendments in is on public process and input—and you raised that—specifically the hospital restructuring commission. Currently, as it's set out in this legislation, there are no terms of reference, no mandates, no limits on the power, and nothing to connect it to the work of locally led planning studies, local DHC restructuring studies, or any of the local processes that are taking place around the province. The government says, "Of course that is what would be intended," but the legislation doesn't say that. We're asking for amendments to set out terms of reference, mandates, limits and relationship. Would you be supportive of those sorts of amendments, and what does that mean for you as a community member?

Mr Tupker: Obviously, we're in support of any opportunity for general public input into the process in the reform of health care. It's necessary. It has to be there. Reforms have to be brought about at the request or with the approval of the citizens of the province. To deny us that opportunity is ludicrous—absolutely unacceptable, from where I stand. There's just no way we can accept that.

The Chair: Thank you very much for your presentation this afternoon. We appreciate your interest in our process.

For those of you who are standing at the back, there are seats scattered throughout, if you want to make yourselves more comfortable.

THUNDER BAY COALITION AGAINST POVERTY

The Chair: Our next group is the Thunder Bay Coalition Against Poverty, represented by Christine Mather. Good afternoon. Welcome to our committee. You have a half-hour to use as you see fit. Questions, should you allow time for them, would begin with the Liberals. The floor is yours.

Ms Christine Mather: Thank you. Good afternoon, ladies and gentlemen. Before I begin, I'd like to introduce the other people of our delegation. They're all members of the Thunder Bay Coalition Against Poverty. With me are Len Maki, Katja Maki, Delores Ponych and Connie McKnight. My name is Christine Mather.

The Thunder Bay Coalition Against Poverty—we call ourselves T-CAP, for the purposes of brevity—is a grass-roots organization of people concerned about the depth and extent of poverty in Thunder Bay. Our primary purpose is to provide support to and advocacy for low-income people. We are a volunteer organization which has no paid staff and which receives no funding other than private donations. We have about 80 members, of which approximately 75% are themselves low-income people.

Before we begin our examination of some of the specific schedules of this piece of legislation, we would like to draw attention to two facts which underlie, and we believe support, any further points we will make this afternoon.

The first fact is that women, senior citizens, people with physical, psychiatric and/or developmental disabilities, visible minorities and immigrants make up the majority of the low-income population. They are also the primary consumers of health care services.

The second fact is that low-income people, historically and currently, do not have much say within the policy-making and legislative processes. This lack of political and economic power makes it all too easy for decisions which affect them to be made without soliciting, listening to, let alone taking into account, their opinions. T-CAP believes that this is particularly true of low-income people in the north.

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Having presented these two basic facts, we will now address some of the specific schedules of Bill 26. Concerning schedule F, we will first comment on the new section 6 of the Public Hospitals Act. We have two points to make about this section.

Point 1: This section allows the minister to close or amalgamate hospitals without reference to the wishes of the communities they serve. Given the lack of political clout of poor people, we are concerned that this section could result in hospitals being primarily located in areas containing residents who have political and economic power. We mean by this, of course, wealthy neighbourhoods.

Point 2: This section also allows the minister to decide what services a given hospital may provide. Poor people have mobility problems. Most don't have cars. In the north, it can be many miles to the nearest hospital. Therefore, giving the minister this power could result in poor people not being able to obtain needed services. It is already easier for a rich woman to obtain an abortion than it is for her poor sister.

Still with schedule F, but now concerning the Independent Health Facilities Act, T-CAP has two points to make.

Point 1 is concerned with the redefinition of the term "facility fee" to include any service so designated by the minister. This could result in a facility charging for a

currently insured service. Low-income people's budgets are stretched so far already that such redefined facility fees could exclude them from obtaining health care.

Point 2 concerning the Independent Health Facilities Act is in regard to the minister's power to collect and disclose patient information through this act and through the Health Insurance Act and/or the Health Care Accessibility Act. It is difficult for us to discuss this issue without becoming either hyperbolic or disrespectful. However, we will state that we view this as having the potential to completely change the doctor-patient relationship, a relationship which up to this time in Ontario has been characterized by high levels of trust. This trust has been grounded in the safeguards of confidentiality.

We believe that all sections of society should be alarmed by the minister being given such access. There are, however, some issues specific to low-income people. There are several social workers in our coalition. Their combined experience is that the status accorded to GPs allows them to act as extremely effective advocates for their low-income patients. A patient may confide private familial information to their doctor, who is then able to advocate for the patient to receive quick access to social services which have long waiting lists. Poor people cannot afford private counselling.

We believe that the possibility of ministerial access to confidential information will dissuade low-income people from enlisting their GPs as advocates. Further, when we consider that psychiatric consumer-survivors are a large subset of poor people, our concern rises. Psychiatrists are privy to the most intimate details of their patients' lives and illnesses. This level of trust is considered a necessary component of treatment. We believe that the possibility of the minister having access to psychiatric case notes will profoundly interfere with the psychiatrist-patient relationship, and hence, with the treatment process itself.

Finally on this issue, the committee should be aware that in the north, especially in the smaller communities, the lack of resources results in GPs functioning as front-line mental health service providers. They often act as de facto psychiatrists.

Concerning this schedule in general, we dislike the use of the somewhat vague term "public interest" in many of the new or amended sections. T-CAP believes that too often "public interest" is interpreted by governments to mean the rich public's interest.

Taken as a whole, the changes and new provisions of schedule F leave us profoundly concerned that they will result in a two-tier system of health care based upon ability to pay and ability to travel. This is not to the benefit of low-income people, this is not the platform upon which the current government was elected, this is not just, and this is not what most Ontarians want.

Turning now to schedule G of Bill 26, we have five points to make. Point 1 concerns the copayments for prescriptions for seniors and social assistance recipients. This will cause hardship to both those groups. Research has indicated that copayments of this type can deter people from having their prescriptions filled. It is not hard to see how this can eventually lead to higher health care costs through hospitalization and/or the worsening of the original condition. It can also lead to an increased

usage of social services. This is particularly true of people with psychiatric disabilities. T-CAP views these user fees as discriminatory and as an illusory cost-saving measure.

Point 2 is that we have heard the government quote the figure of \$2 for this user fee. When people live below the poverty line, even \$2 counts. There is also no guarantee that a future minister will not raise the amount.

Point 3 is that psychiatric consumer-survivors, people with developmental disabilities and some senior citizens are often prescribed several medications over a long period of time. This user fee, therefore, represents a particularly onerous burden for people who are already disadvantaged.

Point 4 is that T-CAP believes it is unfair for the government to no longer pay the difference in cost between a generic drug and its brand-name counterpart when the latter must be substituted to treat a person on the Ontario drug benefit plan. As noted in the previous point, certain groups within the low-income population often have to take a lot of medications. Much manipulation of dosage and brands takes place until a hopefully ideal mix of drugs is reached. Doctors should not be hampered in this process by concerns about costs.

Point 5 is concerned with the deregulation of drug prices. Relying on the workings of the free market economy to protect low-income people has never worked; quite the reverse, in fact. T-CAP, therefore, anticipates that drug price deregulation will not work in the interests of the poor but rather in the interests of the pharmaceutical companies.

Now concerning schedule H, we have four points to make.

Point 1: The changes to the Health Insurance Act appear to give the minister the power to delist services based upon criteria other than their medical necessity. We strongly object to the proposed subsections 11(4) and 11(5), which could allow age to be used as a criterion in the definition of "insured service." Excluding a class of persons from service based upon a blanket criterion is surely the very definition of discrimination.

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Point 2: The changes also appear to give the minister authority to delist a service based on geographic availability. We cannot stress too strongly that low-income people have difficulty in travelling to obtain services.

Point 3: The changes also appear to give the minister the power to delist a service based upon the experience of the physician. Here in the north, especially in smaller centres, doctors are often young or intend to practise in the north for only a short period of time.

Point 4: We believe that the last three points add weight to our earlier-mentioned concern about the establishment of a two-tier health system. If certain services in Thunder Bay, provided by certain doctors for certain groups of patients, become uninsured, it is not low-income people who will be able to pay for services in an alternative location or through an alternative physician.

Concerning the Health Care Accessibility Act now, it appears that the bill gives the government the power, through regulation, to allow hospitals to charge fees for services to already insured persons. We are worried about

how poor people will pay for things, such as operating room costs, meals etc. We thought the government promised no new user fees. We also believe that this contravenes the Canada Health Act.

In summation, the Thunder Bay Coalition Against Poverty has grave concerns that the health care provisions of Bill 26 will prove to be disastrous for low-income people. We find it astonishing and contradictory that a government which states that it wants to get government out of the lives of Ontarians is willing to ascribe to itself so much new authority and so many new powers.

We wish also to comment briefly about the process of bringing Bill 26 into law. We have already stated that low-income people do not generally have a loud political voice. It is not to this government's credit that T-CAP's ability to present at this hearing is the result of actions taken by the opposition parties.

While we are grateful that those actions were taken, we are still not satisfied with the level of public input allowed into Bill 26. This is a highly complex and physically large piece of legislation which will bring many important changes to Ontario. Too little time has been allowed for the public hearings. Too few groups have been allowed to present. Too little time for analysis has been allowed to the groups who are presenting. At T-CAP we have no secretaries, no lawyers, no policy analysts. We only heard that we would be presenting five days ago and therefore we have not been able to do as competent a job for the government as we would wish. We still have not heard if we will be allowed to present on the other schedules of the bill.

This is a government which talks a lot about efficiency. Giving too few people too little time to do too much work is not our idea of efficient governing.

Thank you for your attention to our presentation this afternoon.

The Chair: You've left about four minutes per party for questions, beginning with the Liberals.

Mr Miclash: Thank you very much to the coalition for your report here today. I'd like to read from the Report of the Mike Harris Northern Focus Tour. This was a report done back in January 1995, and it was certainly floated around in June 1995. I quote: "We need answers, not made-in-Toronto policies but solutions based on input and ideas from the people who live and work in the north."

I think your presentation today has highlighted the fact that there was very little input into the drafting of Bill 26. Were you or do you know of any group that was consulted during the drafting of Bill 26?

Ms Mather: We were not consulted and we know of no group that was consulted. That doesn't mean there weren't some, but we don't know of them.

Mrs McLeod: Thank you for the presentation. You have very clearly covered so many of the areas of concern. I'd like to ask you about each one of them, but you've done it so clearly that maybe I'll try and take you the next step or two.

Ms Mather: Don't do that, Lyn. I'm nervous enough as it is.

Mrs McLeod: You note, as well as the impact of copayment on those who are on the drug benefit plan,

that the deregulation of drug prices could also be a problem for those who aren't on the drug benefit plan but are still in a low-income group. One of the things the Minister of Health has said is that they think the way drug prices will actually come down is that some pharmacies will drop their prices, and others of course may not drop them as much, so the sick individual should go from pharmacy to pharmacy bartering for the best drug price.

I wonder if you'd like to comment on the people you work with and how feasible you think it is for a single mom with a sick kid to go bartering for the best price.

Ms Mather: Certainly. First of all, I'd like to say that bartering seems to be a very common strategy this government suggests for low-income people, isn't it?

Low-income people, as I have pointed out over and over and over again in our presentation, don't have cars. The very work of T-CAP is hampered because, among the 80 of us, there are six working vehicles. If you're a single mother with a sick child, you are not going to be able to go from pharmacy to pharmacy seeking out low prices.

I would like to reiterate that a free-market economy does not work in the best interests of low-income people. It doesn't. The facts are there. We don't have to guess. We know that.

Mrs McLeod: I know Mike has questions, but I have to make the point that with every presentation we learn something new. You've made a point here, and it had come up yesterday and I hadn't fully understood the new point, about delisting of service based on the experience of a physician, and how in northern communities often a physician may be doing an area that looks like a specialized area; they may be trained to do it. We could really risk losing the services, so thank you for that.

Mike, I hope I've left you some time.

The Chair: Not much.

Mr Gravelle: I want to publicly pay credit to the Thunder Bay Coalition Against Poverty for the work you've done in giving a voice to people who are not normally well represented. You've done some remarkable work and I've certainly enjoyed working with you.

You've brought out some other interesting things in terms of potential age discrimination in 11(4) and 11(5).

Could you tell us about the human dimension, how the people you represent and speak to are feeling? I know there's a level of fear with the social assistance cutbacks that happened earlier. Could you just tell us and the people in this room something about how people are feeling as a result of the actions this bill may be bringing forward.

Ms Mather: Constance McKnight works very closely with one of the most disadvantaged groups of low-income people. I'm going to ask her to answer that question.

Ms Constance McKnight: There's just so much fear and anger, especially among our psychiatric community. I do a lot of work with the coalition, but I especially work with psychiatric persons, and there's the fear of our records being made public. It's already hard enough to go out and ask for the help, but to go to a pharmacy and try to barter for something when you can't even walk into a store because you're isolated and fearful and just so

scared, to go in and try to barter for something you need and there are so many other people who have psychiatric disabilities and who don't come out and talk about them.

A number of social service people, maybe counsellors and stuff, are psychiatric survivors and already can't get the help they need because if they disclose they are psychiatric survivors, they feel they will be in jeopardy of losing their jobs. I used to be a social service person and now I'm working in the psychiatric community, and it was a very hard thing for me to do. There is that level of fear.

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There is the issue of medications. That makes me very angry, because there is a number of people with concurrent disorders, meaning they have addiction problems and psychiatric disabilities. For them to go to a pharmacy four times a week and pay \$2 every time they go to the pharmacy—they can't afford that. Neither can the seniors. There are so many people being let out of the hospital already, and how many people are going to lose their beds and how many people are going to be discriminated against because they are low-income people, because they do have psychiatric disabilities?

The Chair: Thank you very much. Ms Lankin, you won't mind if Mr Gravelle used a couple of minutes of your time, will you?

Ms Lankin: Of course. I object absolutely, fundamentally—loudly, if you make me. Actually, I will try to keep my questions brief.

Thank you for your presentation and for your contribution in response as well. It's very important to hear from people in terms of how they view it's going to affect their lives and the clients they work with. You've done an excellent job, so you shouldn't be nervous at all, Christine.

I want to read you something:

"The people of northern Ontario have given us a clear message: Their needs and concerns are not being met by provincial government. They feel left out of the decision-making process. Inappropriate and unnecessary laws and regulations, designed to meet the concerns of the urban south, are being imposed on them...."

"This report outlines the ideas of the people of northern Ontario for the real change needed to accomplish these goals in the north and the commitments we are prepared to make on their behalf."

The very first commitment is, "Giving northerners a greater say on policies which affect them."

I am reading from the Mike Harris Northern Focus Tour and his comments on health care. Do you feel the government has lived up to that commitment with the introduction of this bill?

Ms Mather: Most definitely not. There doesn't seem to be anything we can find in the health schedules that recognizes the difficulty that everybody in the north faces in travelling for services, and certainly it doesn't recognize the difficulties that low-income people face. In Toronto, you go to the subway station; every 10 minutes there's a train. It isn't like that here. On the bus route I live on it's every 40 minutes and on the weekend it's every 80 minutes, and on statutory holidays there's no bus service. If you live in Nipigon, it's an hour's car

drive from here, and if you have no car, there's a Greyhound or a Grey Goose bus schedule you can use.

This legislation does nothing, talks not at all, about the difficulties that low-income people in the north face accessing services simply because of geographic considerations. It doesn't, like all this government's actions, recognize that the cost of living is a great deal higher than the cost of living in the south. The 21.6% cuts to social assistance recipients' benefits have brought increased hardship up here because our food costs more and we have the third-highest cost of housing in Ontario. Those two factors put together mean that low-income people in the north are affected to an incredible expense.

Ms Lankin: And in terms of determinants of health, this is a very, very big blow.

Ms Mather: Absolutely. Thank you, you added my point.

Ms Lankin: I wanted to ask you about a couple of other areas in your presentation; I'm going to fold them together. In terms of determination of medical necessity and copayments for hospital insurance, basically your concern was around a two-tier system and the Canada Health Act. We've heard the government say it's not its intention to use those sections in any way that violates the Canada Health Act, and we're asking them to make amendments to put that protection in.

You've also raised your concerns about the privacy of health information. Ms Johns will tell you they intend to amend that section. Mr Clement, if he were here, would argue with you and say the bill doesn't violate your privacy at all. Would you like to hear Ms Johns today put on the record that they intend to amend that section in accordance with all the recommendations of the best expert in this province, who is the privacy commissioner? If we could get that commitment from her, we wouldn't have to argue about this in community after community.

Ms Mather: I have two responses: Yes. The second response is that you asked me so many questions that I can only remember the last question, to which the answer was yes. If you want to go back to the first question, I'll try to—

Ms Lankin: Maybe we'll just let Ms Johns respond with whether she's prepared to make that commitment.

Mrs Johns: Thank you again, Frances, for your continual efforts to put things in my mouth.

I'd like to thank you for your presentation. I appreciate a number of the comments you made. I was going to say, before Ms Lankin said it for me, that the Minister of Health will make sure we stay within the guidelines of the Canada Health Act, just as she suggested I would say, so she is becoming part of my mind.

I want to talk about page 2 with respect to points 1 and 2. You're talking about people's ability to have a say in how their health care is distributed. In point 1 you're talking about institutions: hospitals, for example.

With this bill we've amended a number of sections, but we haven't in any way touched the district health council, at this particular point. Is the district health council not meeting the needs of a certain segment in the community? That's maybe what you're suggesting in point 2; I'm not sure how I'm to understand that.

Ms Mather: First of all, we are not asking the district health councils to hear our concerns, we're asking the provincial Conservative government to hear our concerns.

Mrs Johns: But we're using the district health council to be able to decide how hospitals should be restructured. That's the vehicle for public input.

Ms Mather: Here and now I would like to focus on getting across to the government's representatives what we feel. I can explain these points in more detail, if that's what you're asking me. I don't want to be laying any blame on our local Thunder Bay District Health Council.

The point we're trying to make in point 1 and point 2 is that we feel it would be very easy for wealthy citizens to do effective lobbying with the government to have hospitals stay open in their areas and that it would be harder for low-income people to do effective lobbying to have hospitals stay open in low-income areas.

Point 2 says again that most poor people don't have cars. The minister is being allowed to decide what services a given hospital may provide, so say T-CAP or another group like us lobbies like crazy and we manage to save a hospital in a low-income neighbourhood and the minister decides that hospital will not provide such and such a service, low-income people would have great difficulty travelling from their low-income area to the more fully serviced hospital within a rich neighbourhood.

That's our concern about the potential of those sections. Is that clearer now?

Mrs Johns: I'll talk to you after and go from there. I'll talk about the direct substitution. I don't think I got the answer I wanted to hear, but maybe you want to tell me outside so I can understand it better.

Ms Mather: Maybe I can explain it better.

Mrs Johns: Okay, go ahead.

Ms Mather: When I was saying we're concerned about talking to the government's representatives, it's because this legislation appears to give the minister some kind of all-inclusive power. The DHC may produce some massive reports—I used to work for the DHC as a mental health researcher, and I've done them myself, this thick—and the minister can turn around and say, "Whoops, don't like that one." That's our concern. Is that clearer now?

Mrs Johns: Yes, that's clear. Thank you very much. I appreciate that.

The Chair: You have about one minute for a quick one.

Mrs Johns: Yesterday we heard from someone, it must have been a pharmacist, talking about substitution, that a lot of people can take—in the particular example they gave us, 6% of people couldn't take a substitute drug. There are such demands on the ODB plan right now and on our need to keep as many drugs on the plan as we can. Do you feel from your recommendation that there should be no substitution?

Ms Mather: I think people are poor because of characteristics of our society. The way our economic and social system works is that there is a group of people in society who are poor. If our society works so that there are poor people, our society has the responsibility to provide them with necessary medical care, therefore—to get to the end of that long, complex preamble—doctors should be able to prescribe the drug the person needs regardless of that person's income.

The Chair: Thank you, ladies. Not "ladies"—I'm sorry.

Ms Mather: Women and man.

The Chair: Thanks very much. We appreciate your interest.

Ms Lankin: I was just wondering if I could place on the record, in case there was anyone in the room who didn't notice, that Mrs Johns did not give the commitment on the amendments to the privacy information.

1400

JAROSLAV KOTALIK

The Chair: The next presenter is Dr Jaroslav Kotalik. Welcome, Doctor, to our committee. You have a half-hour. Questions will begin with the New Democrats, should you allow time for them. The floor is yours, sir.

Dr Jaroslav Kotalik: Thank you. Mr Chairman, ladies and gentlemen, I should state at the beginning that I am perhaps the only one today who is not speaking on behalf of any particular organization or profession or group. I'm really making these comments as an individual. Of course my remarks will be coloured or formed by what my background is, undoubtedly, and I feel I have to reveal that to make my comments understood.

I am a physician who has practised in this community as a cancer specialist for over 20 years. For over a decade I had the responsibility for administration of regional cancer services. I have for the past several years concentrated on the study of biomedical ethics and medical law. It is strictly from the perspective of bioethics, of bioethicists, that I am going to address to you some of the remarks today. Obviously, I will be referring to the sections in schedules F, G, H and I in Bill 26.

Ethics is a discipline which looks at the question of how we recognize, articulate and then treat the things that are of value to us. An ethicist examining Bill 26 will recognize that the bill does not define values in health care but in many of its provisions actually tends to negate, threaten and ignore the values which we, until now, have taken for granted and which created a common base and underpinning of our health care services. There are four areas where it is most obvious and I want to make basically four comments of that type.

The first one relates to the obligation of our society for health care. For the past 40 years we have built and perfected the notion that our society will provide health care to all our citizens, regardless of their condition and their ability to pay. You could argue that this responsibility for the access to and cost of health care initially started to cover the necessary medical interventions. Later it was extended to the interventions that could be potentially beneficial and eventually started to mean that all kinds of health care interventions desired by the user or by the provider should be given free to the user.

You could say that we now have proven that our society cannot afford this, that we have to roll back such generous privileges. You could be right in making that conclusion, but the ethical issue here is that when you suddenly pull the carpet of values from underneath our elaborate construct of health care services, the whole building may collapse. Before making organizational and financial changes which may be necessary, we have to

carefully examine and redefine the values that are valuable and should be retained, and those which are no longer useful and should be discarded.

In such a public discussion, both the health care providers and the health care users need to be involved and should lead to a creation of a new consensus. It could happen with an introduction of a new bill to Parliament, but I'm afraid it's not going to happen with this bill, given the fact that it's an economic bill and given the time constraints which we have at the present time.

The bill seems to be concerned with economic criteria and wants to apply strictly economic criteria without evaluating how these will impact on the health of the population, what values are being promoted, what values are being tossed aside and the consequences of all those actions.

The second point that I wish to make concerns the new level of decision-making in health care, which Bill 26 promotes. You probably will agree with me that part and parcel of our ethical notions about what is proper health care in Canada has been that the actual content of the health care, the particular intervention for a particular patient, has been decided between the patient and the health care practitioner. Of course there were always local and regional boards which made this or that available or unavailable, and the Ministry of Health which funded it or created various guidelines. There was always that macro and meso-allocation decision made outside of the caregiver-patient relationship. However, the actual concrete decisions were always made in this context.

When you read Bill 26, you cannot fail to see a bureaucrat sent by a big government sitting right between the caregiver and the user or the patient listening to every word and being prepared to block or veto anything which is being decided in that relationship, and stop the whole process or make the caregiver ineligible at any moment of the time to terminate this relationship. The last couple of decades we were strengthening the position of the patient in that relationship. His autonomy and self-determination are important values that bioethics is trying to defend and also expand.

I believe that with Bill 26 both user and provider will lose the ability to determine which person, which drug, which facility to use. We would like to see that the people of our province, better than ever informed and sophisticated about health care, can take increasing responsibility for their health. But Bill 26 seems to suggest—not desiring so but nevertheless seems to suggest—that the government or bureaucrats should have all the responsibility and that neither citizens, as users, nor the professionals can be trusted. I believe that this cannot but undermine the sensitive relationship of trust and confidence between the patient and the caregiver, which is essential for healing and recovery.

My third point is about fairness. Let us assume that the structural and fiscal changes or the harsh prescriptions which the bill contains, all the changes in the health care delivery, are necessary to make the public sector solvent again. But if this is the case, should the bill not allow sufficient space, sufficient mechanism to alleviate some of the adverse effects to mitigate some of the unfairness and injustices which may appear in individual cases?

A typical situation would be this: Let's say that the minister will decide that for certain medical problems only a particular intervention can be available. The health care provider, keeping in mind the special bond of fiduciary trust and responsibility to the patient, nevertheless must inform the patient about various alternatives which are available. The health care provider will have to indicate at that time that some intervention which he would recommend is not an insured service, yet it may be more advantageous for a patient, given his particular situation. Given this kind of information, should a patient not be able to decide if additional services are worth the cost which he will have to pay from his own pocket? If this would be the case, the patient would have to turn to the private sector for such service.

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Given the realities of health care in Ontario, is it fair to enact a law which places severe limitations on the kind and volume of health care services paid from public funds without assuring that facilities, staff and necessary infrastructure are available to provide additional services to be paid by the patients?

Is it not offensive to our sense of human dignity and liberty that no appeal mechanism will be put in place that will arbitrate cases where denial of public funds for certain interventions could be seriously unjust to the patient? Is it not unfair that private insurance is not available for a full range of services that can become uninsured for those who would wish to buy such additional protection?

I am putting those comments in questions because, as you probably realize, there is a great deal of division, for people who are examining the ethical issues and underpinning of our health care, if in fact a two-tier system is ethically proper and justifiable. The fact is that until now this has been a theoretical discussion, but now we're coming to the situation that that actually is going to happen. The same as I've started to publicly speak, asking those questions I would not have probably asked six months ago, I suspect that the others are having similar concerns.

One of my colleagues put it in a way which perhaps expresses this very well. If you are a captain of a ship and that ship is sinking and you don't have enough boats for all the people, are you ethically correct if you prevent people from swimming ashore just because some people can swim better than others? These are the kinds of questions which will have to be asked with Bill 26.

My final concern is about infringement of our established standards of confidentiality of personal information which is given by the users of health care services to their health care providers. Such information about one's private affairs is given explicitly to facilitate personal care, and the law and customs prevent care providers from releasing the information to anyone without consent of the person. For example, data of this type can be ethically used for research only if the identity of the person involved is hidden.

Situations where the disclosure of such confidential information from health care records could be ethical without consent and without a court order are very rare instances, where important public interest, particularly the

life of a person, is at stake. This is how the courts in common law are looking at questions of the public interest. As far as I can say, there's not been public interest in the sense of release of information interpreted that represents possibility for economical savings or improving efficiency.

A bill that would allow release of personal confidential health information to the minister because of the fiscal concern and without proof of important public interest may have a serious effect on the way people relate to health care providers and how they share their information. I think we have to be aware that besides how the confidentiality and privacy of information of health care speak a lot about how we value privacy and how we value respect for persons, it also has important practical implications. People will not share their confidential information which is essential for decision-making in the health care sector unless they will be assured about the confidentiality, and if they don't share, then you will be making wrong decisions. So the cost and economic impact of not protecting the information in the health care sector could be also significant.

Given this level of complexity of the bill, I may be perhaps misinterpreting some of the provisions and I will be glad to be corrected. Nevertheless, I believe that a bill that seeks to achieve fiscal savings will in fact change the moral values that are underlying our health care and will do so without trying to carefully reformulate those values, redefine them, create a consensus which would be then in fact binding on both users and providers of the health care. It may cut citizens off from health care intervention which their care providers may consider appropriate and will do so without opportunity for appeal or for purchase of the health care desired.

It promotes such centralization of health care decision-making that it in fact allows the Minister of Health to practise medicine without a licence and will likely seriously undermine that important patient-caregiver relationship which is essential for healing and recovery.

It raises serious concerns about privacy and confidentiality of personal information, both for providers and users. The bill may enforce saving and may mandate efficiency, but for an unknown and unexamined cost of human health.

The Chair: We've got about four minutes per party left for questions, beginning with Ms Lankin.

Ms Lankin: Dr Kotalik, thank you very much for your presentation. You are the first person who has come forward to provide the committee with this type of analysis from your perspective and from your expertise. I think it is very important and I think it's an area that we need to explore.

I believe you've hit the nail right on the head in terms of the concern that I and a number of people have with the bill. There is a set of values inherent in our system today, and while I know that the government members have said and would say that basically we all still share those values, the problem is, the bill is not reflective of that.

The bill provides incredible powers for decision-making to be undertaken which, at the very basis of it, leads to some of the concerns you've raised about cutting

out certain areas of activities which will necessarily lead to a demand for those to be picked up by the private sector, for those who can afford to purchase to do so. That will be the result. That's why many of us have talked about leading to a two-tier system, to privatization. Sometimes that sounds rhetorical, but it's an inevitable result.

The problem I have is that we've not had a discussion that that's the direction we want to go. The bill takes us in a direction that we haven't debated and the bill doesn't set out the values or the intentions of the minister and how he is going to use the powers. We hear assurances but we don't see it in legislation.

I am just so profoundly moved by your presentation and feel that it should be compulsory reading for every member of the Legislature at this point in time.

Could you tell us the state of debate with respect to these changed values that you are aware of within the Canadian jurisdiction or in other jurisdictions? What do you think we would need to do to have an appropriate debate to reach a societal consensus on whether these are the kinds of changes that we would want to undertake or not?

Dr Kotalik: I'm not probably an expert of the type you would need to make such a recommendation to your committee, but for one thing, obviously, it would need time. That's the first thing, which we don't seem to have in this instance.

It would need really a major effort from all levels of government and need activation of all the mechanisms which we have in our society which can relate to health care. The fact is, we have a professional group which is perhaps well organized and has been able to articulate its values and its positions and so on. On the other hand, we don't have organized patients or users of the system in some way, so you have to find some mechanism to bring that into the discussion.

I would think that discussion should really take place at multiple levels. You really need a resolution that there's a field of academic ethics, bioethics, which I am sort of getting some information on, and there you need certainly much more debate and you need the opportunity for people to meet. You have to ask those people. I don't think they have been really asked, the people who are dealing with it, how they would approach the situation. But I think you need to have a discussion at the community level, and here by "community," I mean the one like Thunder Bay or one in northwestern Ontario, even a small one. You really need to bring that down to the basic level.

1420

One thing that is happening with the ethics of health care is, it seems to substitute almost for all the ethics in our society. It's becoming kind of a lingua franca—what's the better term?—of the ethical confirmation in our society. We're sorting out who we are as a society quite often, publicly and privately, the way we handle ethical issues in medicine and associated biological sciences. When you look at the daily newspapers, the ethical issues which most commonly come up are related to the review of health care. I would think that the effort that would be put into formulating such a consensus in

health care would be very important, not just for that one field but also for society at large.

The Chair: For the government, Mr Clement.

Mr Clement: Thank you, doctor, for your presentation. It certainly was mind-expanding. I want to assure you that this bill is not the alpha and the omega of discussion of health care in Ontario. It may be the alpha, but it's not the entire picture, and I expect that we will have numerous discussions in the Legislature and in society as a whole where we can flesh out some of this.

Let me turn to the question of values and how public policy and legislation ultimately reflect those values, because I want to add an addendum to your theory. This is, I guess, my theory as opposed to your theory, but I want your reaction to it, and that is that the current system, the so-called status quo, which is in fact a deteriorating status quo, was creating de facto rationing, two or more de facto tiers of health care delivery, de facto waits and queues in the system, de facto to keep doctors in northern and rural Ontario.

That is a shift of values, but there was no discussion about that. There was no possibility of discussion because that was the status quo. So can I put it to you, if I can look at the glass half full for a second, maybe Bill 26 at least allows for these discussions to be held, for these issues to be addressed?

Interjection: Before the end of the month.

Mr Clement: No, not at all. The whole idea is that now we start the process. This is not the end of the process, just the beginning.

Dr Kotalik: I agree with you on the first point you made. I certainly was unhappy also, as many of us were as citizens and users and as the providers, that the many things which happen in our health care were a quick, rapid improvisation of trying to fix the situation fiscally without actually looking at the health consequences, without a long-term view of how it will affect the health care status, what's going to happen to the relationship within society and so on. So I fully agree with it.

If we would have a health bill to discuss, and with appropriate analysis and with an appropriate white paper, whatever it would be, I think we would probably be having a different discussion. But the fact that I am the first one who is raising this question, it seems to me it is going to happen that people do concentrate on the things which are more immediate, which are more practical, which affect the actual treatment or the way health is remunerated, but we will not be getting to discussions of those values even with this bill.

I agree that the bill is doing openly many of the things which previously were happening in our health care and were covered by pretending that it was just extending the old 1985 idea of health care which is available to everyone everywhere without any cost.

Mrs McLeod: I too want to express my appreciation of your presentation, both because of a thoughtful theoretical analysis and also because I can tell members of this committee that it comes from somebody whose practicality and perseverance has almost singlehandedly ensured that we can provide a quality of care to cancer patients in northwestern Ontario. I think that lends weight

to the theoretical concerns that you've expressed to us today.

I'm glad you began with the premise that one of our values has been to provide quality care regardless of ability to pay. Unlike Mr Clement, I'm concerned that this bill is the omega and not the alpha. It is certainly not the alpha, the beginning of discussions. It could lead to a serious erosion of that basic value that we have held so strongly.

I wish this discussion was about preserving health care. It's about finance, as you have noted, and that's why this is a Ministry of Finance bill. I wish too that the discussion that you've suggested needs to be held—and you're not actually the first to suggest it. A physician in Sudbury also said yesterday that we needed to begin the discussion about limitations on our access to medically necessary in order to determine what we can afford, that that discussion needs to take place in a forum where it can be thoughtfully considered by everybody affected. Unfortunately, we won't even get to debate those kinds of issues. We won't even get them in the Legislature because "medically necessary" will be determined by regulation.

It's in that context that I want to place one specific question—only one; there could be so many—and I'll ask this question because I think it is a totally inappropriate question to ask in this forum. The only reason I ask it is that it's the kind of question that we're driven to ask because of this bill, and it's the fact that age can be a criterion for determining what is considered medically necessary. I understand that that is not an entirely new piece of legislation, but it becomes new in the context of a bill that says, "We will pay for services in the public health care system that are prescribed"—and that is new—"services prescribed for conditions under terms and conditions determined by regulation." All of that may be a contravention of the Canada Health Act as it now stands.

A terrible question to put before you and yet a question that's raised by this bill and I wonder if you would comment.

Dr Kotalik: There are probably hundreds of books and thousands of articles in bioethics which are looking at the possibility or impact or meaning of discrimination by age, and the debate, as far as I know, is by no means closed. Obviously some countries which we consider very civilized, like Britain, have been using it for years.

I think probably there will be no sacred cow in the discussion which we'll have to make, and age may not be necessarily the one which we will always protect. But it seems to me that what I only advocate is that the values which we want to change really have to be very carefully articulated and looked at.

I must say I'm not aware that age is actually an issue in the bill. I haven't noticed it, but there are probably a number of other things I haven't noticed in the bill, given the complexity and the effects on the statutes, which I am not familiar in any detail with. But you could probably single out a number of other similar factors which may need to be considered.

I cannot give you a definite answer, but I would only say these are the types of issues which really need to be

brought out into the open before we actually decide on some sort of structure or procedural changes which will lead to either dismantling of certain values or instituting totally new values into our health care.

The Chair: Thank you, doctor. We appreciate your involvement in our process and your presentation this afternoon.

Ms Lankin: Mr Chair, I was wondering if I might make a request, and I will understand if my request can't be met.

Dr Kotalik did not have a written presentation that could be distributed and in fact some of his comments, I think, also would be helpful. If there is any way, recognizing that we're travelling, that Hansard could attempt to provide committee members with a transcript of his presentation—and if so, also the questions and answers—but most importantly the presentation, I would find that very helpful. There are some points in there that I would like to review and be able to ask questions of other presenters as we continue.

I recognize it's a difficult request and if it's not possible, fine, but as soon as would be possible, that would be very helpful to me as a committee member.

The Chair: Normally, when would we get that? Monday?

Mrs Beth Grahame: Friday or Monday. I'll put in a special request.

The Chair: Fine. All right. Thanks, Ms Lankin.
1430

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 268

The Chair: Our final group is the Service Employees International Union, Local 268, represented by Jack Drewes, the president, and Glen Chochla as a member. Welcome, gentlemen. You have half an hour of our time. Questions, should you leave time for them, would begin with the government. The floor is yours.

Mr Jack Drewes: Good afternoon. My name is Jack Drewes and I'm the president of Service Employees International Union, Local 268. To my immediate right is Brother Glen Chochla. He's Local 268's organizer.

Our Local 268 stretches, and our jurisdiction, from the Manitoba border to approximately the Algoma border near Thessalon. We have right now 1,700 members in Thunder Bay and district hospitals. We have another 1,000 in the Thunder Bay district health care system. We have a total of 800 members in Sault hospitals as well as 200 in other health care systems in the Sault. This adds up to a total of 3,700 members in our local, based in Thunder Bay, in the health care field. I believe we are the largest health care union in the Thunder Bay and Sault Ste Marie areas.

SEIU members and all Ontario workers owe a great debt of gratitude to the members of the Legislature who had the courage to fight for public hearings on this legislation. The contempt and disdain this government showed to all Ontario in a vain attempt to hide this legislation and ram it through the Legislature during the day of the financial statement shows the true colours of this government and what we are in store for. I think the

government members should be ashamed of themselves and apologize for this breach of public trust. More hearings are needed due to the vast number of groups that did not have the opportunity to exercise their democratic rights.

Mr Glen Chochla: I'd like to talk a little bit about collective bargaining rights and how they're affected by Bill 26. It's probably a bit of an unusual place to start, but I want to talk about physicians. It's a bit of an unusual place for our union to start because our people, our members, are really at the low end of the health care pyramid and physicians are at the top. It's an unusual situation where those at the top of the pyramid and those at the bottom have so much in common in terms of their basic collective bargaining rights.

What Bill 26 has done to doctors has extinguished the contractual rights that they have through their agreements through the Ontario Medical Association with the Ontario government. The bill also gives the government the power to decree, amazingly enough, that interest arbitration awards by arbitrators in favour of—not in favour of, but in terms of what goes into an agreement between the OMA and the government—are of no force and effect.

Why are our members so concerned about those at the top of the pyramid? The basic reason is that collective bargaining rights, whether we like it or not, are a cornerstone of a free and democratic society. They're one of the things that distinguish our society from a more totalitarian form of government, and historically those totalitarian governments have been of the right-wing nature. When I first heard about the stripping of physicians' collective bargaining rights, I thought to myself other workers are close behind, and sure enough when Bill 26 came out, we saw what it did to hospital workers.

What Bill 26 does particularly to hospital workers is it amends the Hospital Labour Disputes Arbitration Act and it attempts to strip arbitration boards and arbitrators of the independence to determine what goes into a collective agreement. It tries to turn them into head waiters for the government.

The way it does that is that prior to Bill 26, arbitrators had complete independence. What Bill 26 does is it says that whatever economic or financial situation the government wants to create, arbitrators have to bow down and worship that financial situation, have to remain constrained within that financial situation.

Prior to Bill 26, what arbitrators said under the Hospital Labour Disputes Arbitration Act was: "Look, the government creates its own financial situation. It makes decisions on taxation. It makes decisions on spending. Because it has that incredible power, what we are going to do as arbitrators is we're going to look at what the norm is out there in the private sector and we're going to base public sector settlements on what the norm is in the private sector."

The government has taken that away and that seems a bit odd to us because this is a government that is very much wedded to—and I don't think it's overstating it—worships the notion of private sector and private sector businesses and what's good for business in the private sector and so on and so forth. What we don't understand is why in the world the government wants to restrict

arbitrators from doing what they normally have done in deciding what goes into collective agreements for hospital workers.

We're also very concerned that it would appear very much that this government is bent on creating a crisis within the public sector. What they're doing is creating a revenue crisis. They're going to give huge tax breaks to the very wealthy in this province, and they're also going to create a revenue crisis by getting rid of, believe it or not, an organization like the LCBO. It looks very much like they're going to do away with three quarters of a billion dollars of revenue every year by privatizing the LCBO. So you're going to create this revenue crisis and then you're going to tell arbitrators that they have to remain within the bounds of that crisis you have created. That does not make any sense to us; it doesn't make any sense to our members.

You've done the same thing to hospital workers that you've done to physicians, and that's really a concern to us, because the reason we have binding arbitration in the hospital sector and for physicians is that health care has been deemed to be, by the people of Ontario and the governments of Ontario prior to this government, extremely important, and we've decided that we don't want labour disruptions, we don't want withdrawal of services.

If you throw the arbitration system into disrepute the way you're going to, two things are going to happen. First of all, as far as physicians are concerned, you're going to lose physicians to other provinces and to the United States. The second thing is that physicians are going to have to go on strike if they can't come to an agreement with the government on fee schedules. Why are you planning on doing this? It doesn't make any sense.

For hospital workers, our fear in our union, the leadership and staff of our union, is that our rank and file is going to get so discouraged by an arbitration system that does not work that we're going to start having, down the line at some point, wildcat illegal strikes in the hospital sector. I would remind you that just a couple of months ago in Alberta we had exactly that, and that was a situation created by a government that has very much the same kind of philosophy as this government. We're very concerned about that.

The other thing we think may also happen, and it's just as discouraging, is that arbitrators who are used to acting independently, good arbitrators who have done interest arbitration for years, are going to say—I certainly actually hope they do this, because it might stimulate a bit of thinking on the part of government—they may well say, a good number of them I think will say: "We're not going to get involved in interest arbitration. We're just not going to do it, because we don't have the discretion that we need to have in order to make fair decisions on interest arbitration hearings."

Similarly, with respect to pay equity, we have a lot of concerns that the government has done away with the proxy system effective January 1, 1997. The pay equity system, and in particular the proxy part of pay equity, really benefited the lowest-paid workers, most of them in private nursing homes—in our union anyway—female employees, again working at the bottom of the pyramid of the health care system.

Those who did not have male comparators within their workplace could go outside of their workplace to find a comparator in a similar type of institution. That's going to be gone as of January 1, 1997. That affects our members very directly and we're very concerned about that. We think that part of Bill 26 should be struck as well.

In addition, we're also of course very concerned about the reduction in pay equity payments that Bill 26 is going to effect for pay equity plans and the proxy system that have already been posted. There's going to be quite a significant reduction in the payout under those plans, most of which have been freely negotiated between unions and employers.

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Mr Drewes: With Bill 26 Ontario also becomes the only province in Canada with no government regulation for prescription drug costs. Our members have fought for decent benefits at the bargaining tables for years. They and the employers they work for will now have to deal with sharply escalating benefit premiums for the drug plans, especially now that the federal government has given such strong patent protection to drug manufacturers. At the bargaining table now, we can expect our workers to pay for this gift from Harris to the drug manufacturers.

Bill 26 is a power grab by an extreme right-wing government from the communities that our hospitals serve. It gives fantastic powers to the Minister of Health to shut down hospitals or take over their operations. Community workers need more say in their hospitals, not less. This applies also to other health care sectors. It effectively closes out district health councils from the process of hospital rationalization and it makes it impossible for citizens to sue the Minister of Health or any of the other folks he gets to do his dirty work.

All this so that Harris and his fellow political allies can give huge tax breaks to the wealthy of the province and hand over a profitable and publicly owned enterprise like the LCBO to his friends in the business sector. They are also now creating opportunities for the American health care system. Before, it was only Canadian non-profit health facilities that had the opportunity to mine our grey gold. Now the Americans are going to be doing that as well.

In conclusion, two presenters, I believe, yesterday, called this government in Sudbury—I think the word was “fascist.” The head of the CAW said something similar two months ago when he said that this government was the closest thing to fascism that he'd ever seen. I'm not going to use that language, but I think the government should think long and hard about why so many people are using this term to describe this government—ordinary working people in this province. In the words of a member present here, the government has declared war on many, many Ontarians.

I say to you, go back to the big business backroom boys and tell them that the people of Ontario will not stand for this type of leadership. If you do not stop this right-wing behaviour, the province will be split into two warring camps: the haves and the have-nots. I think you've already woken up the sleeping giant known as the Ontario worker.

The Chair: We've got about four or five minutes per party left for questions, beginning with the government.

Mrs Ecker: I think anybody who uses the term “fascism” to describe what is happening in this province does not know history very well, sir, and I will take great issue with the use of that term for you and anybody else that has used it. I think it does a serious disservice to the many individuals around the world over the past several years who have fought fascist governments and died in the cause and I take great offence at the use of that term.

However, I would like to thank you for coming. I would like to thank you for putting forward your views and your concerns about Bill 26.

One of the things I was interested in is your description that we are somehow manufacturing the economic crisis. I would suggest that at the rate of \$1 million an hour going into debt, which is what this province is doing—\$1 million every hour we spend more than we take in—I'm not an economic genius, but that strikes me as being a pretty serious crisis for taxpayers in this province. I am a taxpayer and I have a concern about that.

The other thing that I think is worth mentioning is that you talked about what's good for business and that somehow or other you think this government should be worried about business and link that to arbitrators losing their independence because they're being asked to take into consideration the economic reality of what a public sector employer can pay.

I guess, to me, that strikes me as being common sense, because if there's one message we've heard from people, if there's one message we heard during the last two or three years of consultation with the public, it was that government had forgotten what all of the hardworking families out there knew, that you have to live within your means. That is one of the things that we are attempting to do, and many public sector employers, who, I would suggest, I don't believe are motivated by the profit motive, since they're in the public sector, non-profit, have expressed concern about the fact that arbitrators had made awards that were not paying attention to the economic realities of what was there.

I guess what I would like to ask is, how do you believe that the government—the experts in the health care field have said that the system needs change, the system needs reform, the system needs structure. They've said we don't have time any more, they've said we must move. They've said there have been many, many studies, there have been many, many recommendations. The district health councils have done recommendations, the steps that need to be taken are very clear, and it is time to take those steps.

I guess if we don't take those steps, how do we address the reforms that are urgently needed in the health care system? How do we address the reforms that are urgently needed to protect the taxpayers of this province?

I think it is worth mentioning that 79% of the taxpayers in this province who will benefit from any tax cuts that are brought in by this government make under \$40,000, and I would suggest that \$40,000 in any community is by no stretch of the imagination rich.

So I would ask how you think we should be proceeding with addressing these very real concerns, which the voters have told us are very real concerns.

Mr Drewes: One of the issues you touched on was the lack of funds for the health care system, and I heard it previously, at a previous speaker. That just speaks right to I think the largest issue we have here, and that is, where does the money come from? Where does the money come from, when how many banks made billions of dollars in profits and paid no taxes? How many profit-making corporations make money and pay no taxes? Perhaps we should tax fairly and equitably in those sectors as well, and perhaps we could then afford the health care system that we deserve as Ontarians.

You stated the system needs change, and I don't think anybody disagrees with that, but it doesn't require change on a bill that comes before the Parliament in one day, to be voted on a week later. To me, it constitutes a type of change, but the type of change this province and the workers need is a consultative process. I think we've had our share of dictators in history, and I guess my history is a little bit different. If you talk about fascisms and people who die, I've seen some people on Toronto streets who aren't too far away from that, if that's what you expect from a fascist government, that you have to die for them.

Mrs Ecker: They were there before June 8, sir.

The Chair: Thank you very much, Mrs Ecker. The Liberals.

1450

Mrs McLeod: It strikes Mrs Ecker that with the deficit adding to the debt on an hourly basis we have a financial crisis. It equally strikes me that it makes no sense to add \$5 billion more to the financial crisis with an income tax cut, which is most certainly driving the \$1.5 billion in health care cuts, which is why we're at this table today talking about fundamental changes to our health care system and the way we're governed.

A couple of things, one in your presentation and one not in your presentation, just to keep us specifically on the issues you've raised. I was interested in your comments about the arbitration and also in your suggestion that arbitrators might have some real reluctance to follow terms and conditions so closely set out by the government.

I happened to run into somebody from the arbitrators' association the other day, and they, lo and behold, are one of the groups that has not been consulted nor heard from on the issue. I think your suggestion that we might want to hear from the arbitrators is a very good one.

The question I have is an issue that you didn't touch on and I'm wondering if it's perhaps because your immediate members would not be affected by it, but there's a provision in Bill 26 to allow for a clawback on public sector pensions in the event of layoffs and hospital closures. This is a provision which then deprives public sector workers of the protection that is available to private sector workers. I'm not sure if your immediate members are affected by it, but I'd appreciate your comments.

Mr Chochla: As far as I know, and I haven't looked at this in any depth, the clawback of pensions applies to members of the public service, I believe.

Mrs McLeod: Yes, and a few others.

Mr Chochla: Not the kind of members that our union represents, which is primarily hospital and health care employers in the broader public service. So I really can't speak to that issue, and this bill is of course so huge that we tried to zero in on a couple of issues that were of most concern to our members.

If I may just say a couple of things about collective bargaining, I think that's a very good point, Ms McLeod, that you need to hear from arbitrators, because I can bet that there are going to be some very good arbitrators who are going to be very reluctant to do interest arbitrations, and may even refuse. I think you need to talk to them. I think you should invite them, if you haven't already heard from them, to come and speak to you in some kind of forum.

In terms of a comment that was made about looking to the private sector in collective bargaining, perhaps I didn't express myself well enough, but that's precisely what arbitrators have done under the Hospital Labour Disputes Arbitration Act. They have said: "Let's look at what is going on in unionized private sector workplaces. Let's look as well at the financial constraints that governments are under. Let's take that into consideration as well." But primarily they said, "What's the going rate out there?" and if private sector employers are coming in at 0% or 1%, that's generally what arbitrators have done.

The reason they did that—and this is absolutely critical for you to understand, and I urge you to take the time to try to understand it; I think it's a question of understanding—what they said was: "It is impossible for us to take for granted the economic situation that the government says it has before it. That is impossible for us, to just take that as a given, because"—and please listen to this: Because you control how much revenue you bring in. You decide whether to give a tax cut, who to give it to. You decide whether to increase taxes. You decide whether to forgo three quarters of a billion dollars a year by privatizing something like the LCBO. You decide how much spending you do. And you do all of this with a great deal of power. So it's fundamentally unfair for you to create a situation and then expect arbitrators to make a decision within the walls that you have created.

That's not to say that arbitrators have never given any consideration at all to the government's fiscal situation. But they have said that's not the only consideration.

What you're doing effectively is saying to arbitrators, "You're going to have to deal with the situation that we've given you, and that's it." I think any fairminded person would have to agree that that's outrageous, in the same way that it's outrageous that you're taking away collective bargaining rights for doctors, because that was a good system. Now we're going to get into labour disputes and work stoppages for doctors. Why?

Ms Lankin: If I can just continue along the theme of the importance of the arbitration process and let folks know, because we haven't talked about this here—that clause is actually before the other subcommittee—this affects hospital workers, certain police forces in the province, firefighters.

Mr Chochla: That's correct.

Ms Lankin: There's a broad range of groups that are being affected by this. I'd love to hear from the likes of

the Owensheims and the Swans and the Kennedys and the Pichés and the Martin Teplitskys on this. It would be interesting. There would be some fireworks, I'm sure.

In fact, I remember a time when a previous Conservative government introduced wage controls, which was time-limited, wage guidelines, and the arbitrators said no. In fact, they would not allow their decision-making to be fettered in that way, because they understand that public sector arbitration in fact is to replicate the effects of free collective bargaining, and to fetter the decision-making of arbitrators in that way—and you're right, they have taken all these things into account. But to try and put those kinds of guidelines in place and try and fetter their decision-making in fact leads to the situation where public sector workers will necessarily, by lower wages, subsidize the cost of the delivery of public services.

If you recall before the Hospital Labour Disputes Arbitration Act was in place and the large CUPE hospital strike and the Johnson report, all of these issues were well explored and I really urge the government members please to look at that and to look at the history and how this system evolved.

I just want to ask you one question. Ms Ecker went on at great length about change needed in the system and all these reports and nothing's happened, and if I hear that one more time, I don't know what I'll do, because I'm constrained by parliamentary behaviour.

Mrs Ecker: When did that stop you?

Ms Lankin: So much has happened in terms of changes that are taking place in communities: in communities that are leading reform processes themselves and coming to conclusions and implementing them, in communities like Windsor, in communities like Thunder Bay. Can you talk about what you've seen in your own community in terms of communities grappling with change and being prepared to move ahead and to implement that change? I just hope it will impress itself upon the government that they are not the beginning, the alpha, of the debate on the need for health care restructuring.

Mr Chochla: In this community, for the last three years we've been struggling and the district health

council has been struggling with the question of what to do with the four hospitals we have in the city, plus the provincial psychiatric hospital. It's been a long process. The district health council came out with some recommendations about three years ago that were tabled before the community and the community had a very strong reaction against them.

So the district health council went back to the table and has come up with other proposals and we're continuing to work through the process.

The other thing that has happened in the community is we've had a lot of consultation, and I think some very good consultation, about long-term care reform. That's a critical area to look at when you're talking about hospitals, because if we can care for people in the community, we can do it cheaper than we can in the large institutions like the hospitals.

We frankly don't understand why the concept of a multiservice agency and the labour protections that were in there, which were pretty fair, and the concept that the NDP government was putting forward has been discontinued, and we'd urge you to get that back on line.

I have a lot of criticisms of the previous government, but there were a lot of good things it was doing in health care, and it was getting a grip. I think it was the first government to really get a grip on hospital and health care finances at the same time that it was doing fundamental reforms of the system. I think they were doing it a lot more sensibly than this government, which just announced pulling I don't know how many billion dollars out of the hospital system. The old system, for all the criticisms that I sometimes had of it, that the district health councils were not consulting enough and so on and so forth and weren't listening to us, was much better than what we're getting right now.

The Chair: We appreciate your presentation this afternoon. On behalf of the committee, to the people of Thunder Bay, thanks for hosting us. We enjoyed our stay here. We adjourn now to the Delta Hotel in Ottawa at 9 am tomorrow morning.

The committee adjourned at 1459.

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

Marchese, Rosario (Fort York ND)

Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Johns, Helen (Huron PC) for Mr Danford

Miclash, Frank (Kenora L) for Mr Sergio

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

Gravelle, Michael (Port Arthur L)

McLeod, Lyn (Fort William L)

Pouliot, Gilles (Lake Nipigon / Lac-Nipigon ND)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Campbell, Elaine, research officer, Legislative Research Service

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Première session, 36^e législature

Official Report of Debates (Hansard)

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Journal des débats (Hansard)

Jeudi 11 janvier 1996

**Standing committee on
general government**

Savings and Restructuring Act, 1995

Health issues

**Comité permanent des
affaires gouvernementales**

Loi de 1995 sur les économies
et la restructuration

Questions concernant la santé

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Thursday 11 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Jeudi 11 janvier 1996

*The committee met at 0900 in the Delta Hotel, Ottawa.*SAVINGS AND RESTRUCTURING ACT, 1995
LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en œuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Good morning. Welcome to the hearings on Bill 26 by the standing committee on general government. We have to kind of check outside to see where we are these days. We've been travelling around a fair bit, but it is our day in Ottawa and we're delighted to be here.

I just want to remind the people in the audience that we are very happy you're here. We appreciate your interest in what's happening in our process, but I would like to remind you that the dialogue that takes place is between the presenters and the members at the table.

OTTAWA GENERAL HOSPITAL
HÔPITAL GÉNÉRAL D'OTTAWA

The Chair: Our first presenters this morning are from the Ottawa General Hospital, Jacques Labelle and Pierre Richard. Welcome, gentlemen. You have a half-hour to use as you see fit. Any time you leave for questions will begin with the Liberals. The floor is yours.

M. Jacques Labelle : Nous désirons débiter en vous exprimant l'appréciation d'avoir eu l'opportunité de vous laisser savoir notre point de vue ce matin. Tout particulièrement, nous apprécions le fait que nous avons été choisis pour être les premiers à vous adresser la parole.

En premier, j'aimerais dire quelques mots sur l'Hôpital général. L'Hôpital général est un des plus anciens hôpitaux au Canada. On fêtait l'an passé nos 150 années d'existence. En même temps, l'Hôpital général est un des plus modernes du Canada. Nous avons ouvert il y a environ 15 ans un hôpital tout nouveau, probablement ce qu'il y a de plus moderne en Ontario, sinon au Canada.

L'Hôpital général a été construit pour accommoder 1600 malades. Présentement, nous avons environ 400 lits à l'hôpital qui sont en opération ; 300 accumulent de la poussière.

J'aimerais aussi porter à votre attention le fait que l'Hôpital général est assez particulier, du fait que nous avons eu durant 15 ans des surplus annuels considérables. Au cours des 10 dernières années, la moyenne de notre surplus a été de huit millions de dollars par année, pour un total de quatre-vingt millions. Je vous dis ça simplement pour vous laisser savoir que je pense qu'on a une certaine crédibilité dans le monde hospitalier.

Our presentation will really address only two aspects of the bill, the amendments to the Ministry of Health Act as well as the Public Hospitals Act. We'd also like to say a few words at the end about the patient confidentiality and the concern that has been addressed about amendments that could affect this issue.

In recent years, because of new treatment modalities, thousands of acute care beds have been closed across Ontario hospitals. Just in Ottawa, over 500 beds were taken out of operation and a further 150, which were earmarked for future patient care, have remained mothballed. However, the saving potential of these reductions was never maximized, since the forces at hand did not allow for the concentration of these closures into specific plants, thereby allowing the remaining facilities to operate at full capacity.

Therefore, on the one hand we are not benefiting from the additional savings that would result from ceasing the operation of entire plants and shifting their patient activities to the remaining facilities. On the other hand, overhead costs are occupying an ever greater share of hospital budgets since they must operate much below capacity. Proportionately, we are spending more than ever on the maintenance of brick and mortar and less on patient care itself, and this ridiculous situation can only worsen with the very significant budget constraints recently announced.

The 17 teaching-tertiary care hospitals of Ontario receive approximately 40% of the total funding the Ministry of Health dedicates to all its hospitals. I believe there are about 230 hospitals in the province. This 40% is substantially higher than the percentage of patients they care for. This high funding level was historically justified by the fact that these hospitals were mandated to deliver tertiary care to the citizens of the province and provide training ground for medical students and residents. Both activities contribute to make teaching-tertiary care facilities 30% more expensive than other hospitals.

However, considering that only 20% to 25% of the clinical activities of these 17 hospitals is tertiary in nature, but the number of medical students and residents has been continuously declining over the decade, and that more training is to occur outside these facilities in future years, it is evident that their number can and must be

diminished. Such a move would engender enormous savings without tangibly impacting patient care.

To be successful, to achieve the savings goals and to keep to an absolute minimum its effect on patient care, hospital restructuring in Ontario must rest on plant closures, the concentration of clinical and academic activities in as few facilities as possible and on mandate consolidation where unnecessary scattering of functions exists.

Experience has clearly demonstrated that though this type of fundamental restructuring represents the best way of protecting the superb health delivery system to which Ontarians have become accustomed, local interest groups and power structures will aggressively militate for the maintenance of a hospital system as close to the status quo as possible. They will tend to favour options that protect organizations, bricks and mortar and mandates as they exist, and this even at the expense of patient care. Unless a fundamental hospital restructuring is made to occur in a systematic, orderly and timely fashion, we will end up pauperizing the entire system, forcing all hospitals to provide less than optimal care, confronting large sections of patient populations with mounting waiting lists and eliminating more health care professionals than necessary.

The Ottawa General Hospital therefore considers that parts I and II of Bill 26, amending the Ministry of Health Act and the Public Hospitals Act, are essential under the present circumstances. However, we feel that the Health Services Restructuring Commission should cease its operation at the end of a four-year term, which I believe has now been accepted. At that time, based on the success of the commission, all of the proposed powers provided for in section 6—I'm not going to read them to you; you know them all—should be reviewed with the object of returning as much as indicated to existing ministerial powers. Such an eventuality would represent the best incentive for the savings and restructuring commission to fulfil its mandate effectively and in a timely manner.

Again, we believe the purpose of this legislation is to rapidly and fundamentally restructure and reorient the system so as not to have to maintain a continued heavy hand over it in the future, while protecting our ability to deliver excellent quality care.

A few words about the confidentiality of patient information: The Ottawa General, as a teaching hospital, must open its medical charts to nursing students, physio students, occupational therapy students, psychology students, pharmacy students, as well as to its own pharmacists, OTs, physios, psychologists, social workers, nurses, as well as to its interns, its residents, its medical students, its medical staff and its management staff.

In my 15 years' experience at the Ottawa General, we've had no breach of confidentiality that I can remember that was brought to my attention. Inevitably there are minor breaches, but nothing substantial—only to tell you that as the hospital system exists right now there are many people who have to look into patient charts, even more so in the last 15 years when there's been pressure for us to increase quality assurance as well as economic use of resources. This has meant we've had to form

committees across the hospital involving management staff to continuously delve into the charts to see if there are ways of improving the care and ways of improving the economies of providing patient care.

At first there was a lot of suspicion that this would lead to all sorts of breaches. I can assure you that the process has not led to the breaches, but has led to substantial economies as well as to the improvement of patient care. We're only trying to tell you that it's absolutely necessary, for a well-managed system, for more than one person to look at the medical charts to see how we can better provide care and how we can create or achieve greater economies. That is our presentation. Thank you.

The Chair: We've got seven minutes per party for questions. For the sake of those who are new to the process, basically the Liberals have seven minutes. You can fight among yourselves how you're going to use them.

0910

Mrs Lyn McLeod (Leader of the Opposition): We've reached an understanding as to how we'll manage. We only wish we had voting rights for everyone around the table today.

I'll lead off. We find that there is simply not enough time in the question period to ask all the questions we'd like, and I understand that you really wanted to address essentially just one aspect of Bill 26, even in terms of health care provisions.

It would have been a welcome opportunity to be able to ask you about some of the other aspects of Bill 26 that affect even just hospitals and hospital operations, such as the fact that the Minister of Health has the power to appoint a supervisor without an inspector or an inspector's report to shut down voluntary boards of governors; that this act gives the minister the power not only to come in and facilitate hospital restructuring with a commission, but in fact to operate as a minister outside of the boundaries of the Public Hospitals Act. He's no longer governed by the regulations under the act.

We're concerned that that has some long-term consequences that are rather frightening. Also, there is absolutely no liability for any decisions the minister may make as he carries out the powers given to him under this act. All of those I think would probably be areas where you would have some concern.

I can come back, then, to your focus on hospital restructuring with a specific question. I think everybody would agree that at a time of limited financial resources, we have to look at the best utilization, including the whole question of how much goes into bricks and mortar and the distribution of resources. I guess the concern we have here with the way in which a hospital restructuring commission might work and the way in which the Minister of Health's powers would be exercised is the time of his intervention, the way in which it would be carried out, the community involvement in the planning process and whether the decisions are going to be made in a way that's conducive to the public interest in that community. We have to remember that this is a Finance bill. It came in on the day that \$1.3 billion was taken out of hospital budgets.

I guess the question then following from that is, do you feel that you need a commitment that the dollars that would be achieved from any restructuring that goes on in Ottawa-Carleton—and I know there's been a lot of anguish over it—that any dollars that are saved need to stay in this community or this region to be used for the health care of people in this area? Have you any commitment that this would happen and do you need that commitment?

Mr Labelle: For one thing, I have to go back to your initial comments. We understand that the ministry will be given extraordinary powers, but we're saying for the next four years we're willing to live with this. At the end of the four years, based on the achievements, then we should consider whether or not these should be abolished. But we think that we have to go through extremely difficult, perilous years, and what above all is needed is decisiveness and the ability to get changes to occur rapidly.

Closing hospitals, transferring whole programs, transferring patients, transferring medical staff are extremely complex. If we don't put any urgency on that, I can see ourselves 10 years from now still looking at it and trying to find ways for it to occur. I think that this has to be a number one priority for the next four years, not only to plan it but to get it done, and I'm willing to pay whatever price is necessary to see it achieved.

On public consultation, I can only tell you that under previous governments we, the hospital, have had to do all sorts of public consultation. I'm not at all sure that the people who came to our institution to express their voices really represented the public. They represented particular interests of the public, but the public at large, I cannot say so.

Mr Richard Patten (Ottawa Centre): I'm interested in your qualification of absolute authority, but we want the authority to be for a terminal period of time. I would ask you if you feel that the authority, which by the way is unprecedented in Canada for any Health minister to have absolute authority to micromanage—you just made the point that this was an extremely complex set of circumstances, and the minister, you will know, has talked about the importance of the district health councils throughout Ontario and the participating people who are involved in the whole health care area to get on with the job of looking at how they can best use the resources and find resources that are taken back.

How do you reconcile giving absolute power to one individual in an extremely complex area and the role of the community, in terms of working together and cooperating together in addressing health care concerns, let's say for example for the Ottawa-Carleton area? What role do you see the General playing in doing that?

Mr Labelle: First, I don't think it would be one individual. Obviously, when we talk about the Minister of Health, we're really talking about the Ministry of Health and all the expertise there, as well as the influence of the political process on it.

I can only give you an analogy. We in Ottawa have spent—I don't know—about \$1 million in the last year and a half gathering information to determine how we should restructure, and we find ourselves today not really

knowing where we should go. The process is not paying off. We've had tons of consultation, but we still haven't decided what we're going to do to absorb what we were told is going to be a \$120-million cut, as well as the loss of revenue from Quebec of close to \$35 million, for a total of about \$150 million. We still are not any closer today than we were a year and a half ago when we started the consultation.

Mr Patten: By the way, who said there was a \$120-million cut? Was this a directive from the Ministry of Health?

Mr Labelle: No. If we just take the 18% or whatever and factor in the budgets, we come to about that.

Mr Patten: What would be your position vis-à-vis incentives for the community to identify savings in light of emerging needs or new health care requirements? What should stay in the community and what kind of arrangement or agreement do you think would be important to provide for the real incentives for the health care participants in any particular area to deal with that?

Mr Labelle: I can only talk about my approach, which would be to first achieve the saving and then sit down and see how you reorient the saving. We mix up the process when we start talking about what we're going to do with it, when we haven't achieved it yet.

Ms Frances Lankin (Beaches-Woodbine): Thank you for your presentation. I am interested in the comments you made about the problems you've had in this region in coming to a consensus about what change is required. All the communities we've been to, and many other communities I'm aware of, that are going through the process of determining how their health care system should be restructured and what should happen to hospitals in that context are at different stages, no doubt about it. Some communities have very comprehensive reports and are in the process of implementing them, some have already gone ahead and merged and amalgamated or closed hospitals, and others are at a different place in the process.

You've indicated that you've done the consultation, you've been setting this and you don't know where to go. With this bill, what do you presume will happen? What do you think the minister will do, and based on what information or whose advice for the Ottawa area?

Mr Labelle: We at the General have made our advice known to the ministry. The ministry has its own staff it consulted, and they understand the system very well and they also have ideas.

Look, let's put it simply. We have closed 20% of the beds in this province, so most hospitals are operating at 80% capacity. The business approach would be to close 20% of the hospitals and have the others functioning at full capacity.

Second, there is a lot of duplication. For example, all the hospitals in Ottawa have long-term patients occupying acute-care beds at a great cost. If we were to concentrate all these long-term patients and move them to one facility and change the mandate of that one facility to a long-term-care facility, we could save probably two thirds or three quarters of its budget without any impact on patient care.

I think the ministry officials know that; it's just that it may not be politically appropriate to so recommend. But if we use all the wisdom there is in the ministry, as well as the wisdom there is in the community, and show a determination to accomplish what must be done, to me, it won't be difficult to accomplish.

Ms Lankin: It's interesting. I remember the debates I had with the Perley about becoming a long-term-care facility and the need for that, so I understand some of the politics of the hospitals in this region.

But I have to say to you, it's interesting: Your answer to my question is that the minister should listen to us, to our position. There are others out there in terms of the community—

Mr Labelle: No, I said its officials. They can listen to the hospital community, but above all, it's got to be its officials.

Ms Lankin: And the community at large, I would assume. The reason I'm raising this is because I'm concerned that the bill does need to have some terms of reference and mandate for the hospital restructuring commission and some linkages to the local health care planning process that's been led by district health councils.

I'll give you an example we've heard just this week. In another community the district health council and the community had gone through a long process, had come to a unanimous recommendation which they were in the process of implementing, and because of the lobbying of one particular hospital, the Minister of Health has changed the rules with respect to that restructuring report on one particular issue and has said, "No, I'm not going to accept your recommendation on that, even though there was a consensus."

I think the minister has the right to do that. I'm not arguing against it. But what I fear, given that early indication that it's so easy to go against the community process, is that it needs to be built into the legislation.

Mr Labelle: Except that you have to look at the other side, and let me tell you what's happening right now. Because we have not decided what was going to be in Ottawa, all of us have had to absorb a 5% cut. At the General, it's \$6 million. What are we cutting? Nurses, OTs, physiotherapy. We don't care about the waiting list. We don't have the money. The more time we take to decide what the ultimate outcome will be, the more each facility has to trim and trim, and that's the problem.

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Ms Lankin: Every time I raise this, I feel like you're skirting my questions in defence of the bill. I support restructuring, and if you know my record when I was the Minister of Health, you would know I started many of the communities down this direction.

What I'm saying is that I think it would behoove us to have in the bill some terms of reference that relate what the restructuring commission is going to do to the local community planning process where that has occurred and where that has produced a report and a consensus. I'm really interested that you seem hesitant to support that kind of connection or linkage.

Mr Labelle: To the extent that it achieves the saving that must be achieved, obviously I could not oppose such an approach.

Ms Lankin: It took several questions to get to that point. That's interesting.

One other thing I wanted to talk about is that you mentioned you would like to see a sunset on the extraordinary powers under the bill. There are some things in there, like the ability of the minister to move in and to impose a physician human resource plan and some things that other hospitals have referred to as micromanaging. While they agree with the power to restructure and want to see that happen, they don't want to see the minister or the Ministry of Health step in and micromanage hospitals and make decisions about physician human resource plans, which is something that really should be done in the context of the knowledge of the mix and the requirements. Do you have any comments on that? Do you think those powers are appropriate or should be mitigated in some way?

Mr Labelle: In all honesty, we've been more concerned with the hospital globally than we have with individual elements such as what you're talking about, so we really haven't thought about it, but under—

Ms Lankin: That's a very important piece for hospitals.

Mr Labelle: Let me tell you that under abnormal circumstances, we all do micromanage. When I'm told that our budget's going to be cut by 6%, I begin to run, personally, housekeeping, nursing, as well as medical affairs, because it has to be done by tomorrow and I impose a lot of my will, which I would not do under normal circumstances. I'm saying that we are not under normal circumstances, and I can understand that a lot will be imposed upon us to get there quickly.

Mr Tony Clement (Brampton South): Thank you, gentlemen, for your very significant presentation. I have a few questions to flesh out some of your comments.

First of all, you acknowledge the need to restructure. You've said very forcefully that we have to get past a system where a lot of discussion occurs and a lot of input occurs but there is no way to get from the input and discussion to an actual decision which will reallocate the resources in the fairest and most efficient way.

In your mind, doesn't the decision-maker ultimately have to be the Minister of Health? Isn't it ultimately the minister who has to be responsible, as an elected official, for the system? Do you have any concerns or any apprehensions about that?

Mr Pierre Richard: At some point in time, somebody has to make the decision. We must recognize that the funding of hospitals is the taxpayers, and the source of that is from the province; therefore, the responsibility in funding for hospitals and the political responsibility lies at the ministerial, at the provincial government, level.

What we've seen here is that the hospital system has served us well, but it's all carried on through separate corporations, separate entities, what have you. What we're faced with now—the \$120-million figure was suggested a while ago. Just to stay afloat in this region, we need \$120 million, so if we can save \$120 million we'll stay afloat. There's no question that those savings have to be reinvested, they have to be generated to keep the health care system afloat.

When we look at these powers and when we look at this commission, we see that some of this corporate structure out there has served us very well and I suggest will continue to serve us very well, but there has to be a transitional period to put the building blocks back together and deal with plant closures and deal with reorganization.

The four-year period will allow us to do that, and allow us to do it quickly and efficiently and make decisions. There is going to be lobbying at whatever level, whether it's at the regional level or the ministerial level, but a decision has to be made, so ultimately the decision rests with the funding agency. That's why we have confidence that the restructuring commission will work fairly and in the good interests of the province.

Mr Clement: Let me turn to the issue of public consultation and its interaction with ministerial decision-making. Ms Lankin mentioned a situation that came to the fore in Sudbury. I might add parenthetically that I guess consensus is in the eye of the beholder. I don't think the minister would be saying anything about it if there was consensus in the community; in fact, we saw quite the opposite in the presentations to this committee.

The way the minister perceives this process working, and has said so on numerous occasions, is that there is an appropriate role for the providers to have their input. There is certainly an appropriate role for the district health councils to have their planning and advisory input, which has not been touched by this legislation. It's still sanctified in legislation, in the previous act, and that has not changed. But ultimately, all of that has to lead somewhere to a focal point which is a decision-making authority. Are you comfortable with that advisory, consultative process for the DHC and for the providers, ultimately leading to a decision?

Mr Labelle: I think what will happen is that as the commission is set up, as a few decisions are made affecting a certain community and as the rules of the game and as the process get known, the local communities will start to deliver much more than they have in the past. The point is that we've never known, as a local community, to what extent we could resist, to what extent we have to cooperate and to what extent we have to deliver. Once it's made clear what we have to do, it's amazing how people start to react positively to the reality.

Mr Clement: We've had in previous presentations and previous comments by my friends across the way a concern about the role of the minister and the ability of the minister to appoint supervisors in the hospital setting—as a last resort, obviously. I might add parenthetically again that this power does exist under the existing legislation. We have removed the 30-day waiting period so the minister can act a bit more quickly if there's a paralytic situation in a particular hospital.

As administrators—I'm asking you to speak against your own self-interest perhaps—do you see a role for the minister in very exceptional circumstances to appoint supervisors in certain circumstances?

Mr Labelle: It's obvious that only a handful of hospitals will be affected. No Ministry of Health and no government could expect to maintain power if they were

to exercise this thing in a foolish way on a weekly basis. It's just for us to know that if we don't get our act together, this can be invoked. It's just a form of motivation, as far as I see it.

Mr Clement: I want to turn to confidentiality and disclosure. As I've said at this committee on numerous occasions, the way I read the disclosure and the deemed to disclosure requirements, they are more specific, more constraining in the new legislation than they were under the old legislation. But there are some legitimate concerns out there, because it's something patients feel very strongly about. I was very impressed by the way you deal with it in your hospital to ensure that there's a balance between knowing what's going on in your hospital but at the same time ensuring that there is confidentiality.

If we were able to perhaps strengthen and clarify the confidentiality requirements, are you satisfied that the disclosure provisions are satisfactory in this bill?

Mr Labelle: We have no difficulty with it.

The Chair: Thank you, gentlemen. We appreciate your presentation this morning. Have a good day.

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CANADIAN CANCER SOCIETY ONTARIO DIVISION

The Chair: Our next group is the Canadian Cancer Society, Ontario division, represented by Dr Catherine Lochrin, vice-chair of the medical affairs committee; Alex Bruce, who's a student and a cancer survivor; and Ruth Lewkowicz, who's the vice-chair of the public issues committee. Good morning and welcome to our committee. You have a half-hour to use as you see fit. Questions, should you allow time for them, would begin with the New Democrats. The floor is yours.

Dr Catherine Lochrin: I'm a physician who specializes in cancer, primarily treating lung, breast and thyroid malignancies. I'm also vice-chair of medical affairs at the Ontario division of the Canadian Cancer Society, and in this capacity I am here today. I must say it was a privilege for me to have been asked to present to this committee on behalf of the Canadian Cancer Society. Next to me is Alex Bruce, a cancer survivor and a Canadian Cancer Society volunteer. Beside Alex is Ruth Lewkowicz, a volunteer member of our public issues committee.

Before I begin, I want to state that the views I express here today are those solely of the Canadian Cancer Society and in no way reflect the views of the Ottawa Regional Cancer Centre where I currently work.

Each of us will give a short presentation. I will put Bill 26 in context by providing information about Ontario's current cancer system. Alex will provide a patient's perspective on the proposed legislation. Ruth will speak to the specific issues in the bill which most concern the Canadian Cancer Society. We will then be happy to answer any questions that you have.

The Canadian Cancer Society is a national, community-based organization of volunteers whose mission is the eradication of cancer and the enhancement of the quality of life of people living with cancer. To this end, the Canadian Cancer Society is the single largest source of funds for cancer research.

Through offices in more than 70 communities across Ontario and through the efforts of more than 150,000 volunteers, we provide a range of services directly to cancer patients and their families. In Ontario, the Canadian Cancer Society subsidizes the government's northern health travel grant program for people who would not otherwise be able to benefit from the program. Donations to the cancer society augment the availability of provincial homemaking services.

Our volunteers transport patients to and from regional cancer centres and community hospitals, both for treatment and for follow-up visits. Lodges at the regional cancer centres were built entirely with donations from the Canadian Cancer Society and our volunteers are pleased to provide many hours of service to the residents of these lodges.

Our volunteers are also a major source of supportive care for people living with cancer. They offer people with cancer across Ontario the opportunity to speak with someone who has been there and who share ways to cope with the effects of illness.

Our cancer information service is the most complete source of factual information on cancer in this province and is fully accessible, by a toll-free number, for everyone throughout Ontario.

While the cancer society appreciates the challenges facing the government in its efforts to reduce the deficit, the Canadian Cancer Society has an obligation to make sure that the government does not put in place changes without regard for the human impact, especially on the sick and vulnerable. We strongly believe cancer patients must have timely access to a full range of high-quality care, from diagnosis to palliation, regardless of their ability to pay, no matter where in the province they live.

Our purpose here today is to bring to this committee's attention the potential impact of Bill 26 on cancer patients, particularly in light of the three features I will outline—(1) the changing demographics of Canadian society, (2) the funding and delivery of cancer services, and (3) the advent of new technologies and treatment—all of which are placing increasing pressures on the provision of cancer care.

First, I will address demography and cancer statistics. Who are the people living with cancer or at risk of developing cancer who will be affected by Bill 26? In 1995, an estimated 48,500 Ontarians were diagnosed with cancer and approximately half, 22,400 Ontarians, died of cancer. One in three individuals—I look around this room—is at risk of developing cancer in his life.

The fiscal restraint the government is seeking comes at a time when the health care system is in fact facing increasing demands for cancer services. This is because cancer is primarily a disease of an aging population, and the Canadian population is aging. In Canada as a whole between 1985 and 1995, there was a 37% increase in the number of people diagnosed with cancer; 72% of new cancer cases and 80% of cancer deaths occur among those who are least 60 years old. This is a vulnerable population.

This trend will continue with 1996 marking the 50th birthday of the first of the baby-boomers. As well as increasing demand for cancer services, older patients also

have different needs that do not appear to be met under Bill 26. Ruth Lewkowicz will provide the specific details on these issues.

The second issue is the funding and delivery of cancer care. How will changes in the funding and delivery of what are currently hospital-based cancer services affect people living with cancer? Currently, Ontario spends \$17 billion annually on health care. Cancer care accounts for \$1 billion, which is about 6% of the total health care budget. Although the eight regional cancer centres and the Ontario Cancer Institute provide 100% of the radiation treatment in this province and 65% of the chemotherapy, overall this only accounts for 20% of the total cancer budget.

The remaining 80% of the money used to provide cancer services, that is, \$800 million annually, is for surgical treatments, chemotherapy, hormonal therapy and in-hospital palliation funded by the tertiary and community hospitals. These very same hospitals have been told to absorb an 18% budget cut over the next three years, the very same hospitals that under Bill 26 could experience profound changes to both the volume and the nature of services that they currently provide.

By reducing the length of stay in hospital and by moving hospital-based cancer services like chemotherapy and palliative care into the community, the Canadian Cancer Society must be assured that patients will continue to receive these services regardless of their ability to pay. Can the government assure Ontarians that services moved into the community will have the same protection under the Canada Health Act as services currently provided in hospitals and practitioners' offices?

Bill 26 does not appear to provide such assurances. Opening the door to the possibility of a two-tier health care system in the name of deficit reduction is not acceptable to the Canadian Cancer Society, to people living with cancer or to the population at large.

The third issue I wish to address is new technology. How, in an environment with finite resources, do we determine which new technologies, techniques and drugs to cover? There are many new treatments becoming available. Most are very expensive. For example, in the area of new technology, we have techniques such as MRI scanning or PET scanning. Therapeutic treatments such as stem cell transplants are very expensive, and genetic screening, which is a huge can of worms, is around the corner.

Most new drugs are costly. Last week it was reported in the popular media that Taxol is effective in the treatment of ovarian cancer. Taxol costs \$1,700 per injection, and drugs to alleviate the side-effects of treatment, like nausea, are also considerably expensive.

How do we decide what to fund? There are three important players in making such decisions: (1) the health care experts, (2) the patient, and (3) the government.

The role of the health care team is to evaluate the patient with a particular disease, to pursue the appropriate investigations and, based on this information, to recommend and explain an appropriate course of management for that particular individual.

The patient's role is to participate in the decision-making, but to do so, he must understand the nature of

any proposed treatments, including the potential benefits, side-effects and alternative options of management.

The role of the government is to ensure that throughout the province patients are able to receive the same standard of care, regardless of location and, where possible, that this is the best available care for that individual.

However, amendments to the Health Insurance Act in Bill 26 appear to override the rights and responsibilities of both health care providers and patients in this treatment decision process. This is done by vesting unprecedented authority in the minister and general manager of OHIP to approve and reject insured services. It is alarming that Ministry of Health officials will be given the authority to decide whether a particular treatment was medically or therapeutically necessary. This will be decided retrospectively. Such action would completely nullify the expertise of health professionals specifically trained to make these decisions and ignore the desire of the patient to proceed with a particular course of treatment.

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The decision-making responsibilities of health care providers and patients are also undermined by the fact that a large number of fundamental components of the health care system have been left to be prescribed in regulation. One of the most disturbing instances is determining what specifically constitutes an insured medical service. In this regard, the Health Insurance Act states that services will be covered by OHIP if they are "prescribed services of hospitals and health facilities," "prescribed medically necessary services rendered by physicians," and "prescribed health care services rendered by prescribed practitioners," all subject to, I underline, "conditions and limitations as may be prescribed."

What are these conditions and limitations? Bill 26 provides only two: first, that services be performed in a designated facility; second, that insured services could be restricted based on a person's age. Is the age limitation an indication of the approach the government is going to take as it drafts regulations? What other arbitrary and discriminatory criteria is the government considering? And why is it that only the government is allowed a role in determining what services Ontarians will have access to?

The definition of an insured medical service will have an enormous impact on the treatment options available both to health care providers and patients, but under Bill 26 they will have no role in defining it.

In conclusion, it is apparent that Ontario's health care system is going to be fundamentally altered, and indeed this needs to happen. But the Cancer Society cannot support Bill 26 as currently drafted as the vehicle to bring about this change. The Canadian Cancer Society believes that Bill 26 exacerbates existing demographic and economic problems and in its current form senselessly creates additional problems that will lead to the unnecessary erosion of our health care system.

I challenge any member of this committee to spend a day with me, not as an MPP or as a dignitary but as a tacit observer, and to witness first hand the difficulties, decisions and obstacles that cancer patients in this province experience on a day-to-day basis in their daily lives.

I will now ask Alex Bruce to provide his personal experience and views about what needs to be protected in our health care system, and Ruth Lewkowicz will subsequently outline the changes the Canadian Cancer Society is requesting today.

Thank you for your time and attention.

Mr Alex Bruce: I am a third-year engineering student at Queen's University, I am a Canadian Cancer Society volunteer, and I am also a cancer survivor.

I would like to start by telling you how I started working with other people living with cancer. When I was a cancer patient I had a lot of questions myself, and I wanted to talk to someone about my experience with cancer. Social workers and doctors were always available, but because I had no specific problem, it seemed like a waste of their time to talk to me. Very little time is spent in hospital care, and patients tend to get lonely despite the best intentions of family and friends. So I began looking on the Internet for information, and I discovered, among other things, that the oncologist who pioneered my treatment is from Italy. I was able to get the information about my particular treatment from a database at the National Institutes of Health. Not only did I find a lot of information, I also found quite a few other people with similar stories.

Subsequently, I have become a volunteer with the Canadian Cancer Society. As a CanSurmount volunteer, I can share my experience of having "been there" and offer people peer support from the perspective of a cancer survivor. I also help people find information on the Internet about their particular condition.

As a recent cancer patient and as a volunteer with the Canadian Cancer Society, I have concerns with the proposed legislation outlined in Bill 26. In retrospect, given what I know about the health care system, and cancer treatment in particular, I believe I received the best care and the best medical advice available anywhere. However, I feel, based on my experience, that Bill 26 will undermine the kind of excellent care and medical advice that makes our health care system the envy of many.

My particular cancer story begins in May 1994, just a little over a year and a half ago, when I went to my family doctor with a bad cough. It had lasted for about two weeks. Before going to see him I had lost a lot of weight and energy, but with school exams I figured everyone was run-down. My family doctor gave me some antibiotics and told me to rest. Soon it became obvious there was something abnormal, and he ordered a chest X-ray, which showed the first signs of disease. I was quickly referred to a specialist and then to a surgeon, who performed two biopsies on me. I spent one night in hospital for the biopsies.

By the end of June, when I met the first oncologist, I had been diagnosed with full-blown Hodgkin's disease. From the time I first went to my family doctor until I met the oncologist who treated me, about six weeks passed. Apparently this is a normal amount of time for a diagnosis, but it seemed like an eternity to me.

My oncologist, in consultation with other specialists at the Toronto-Bayview Regional Cancer Centre, decided on an unusual hybrid of a standard treatment. At first there

was a question of whether they would be able to offer me the treatment they wanted to, because one of the drugs was difficult to obtain. Eventually they were able to get the drug.

Once I began my treatment the question of cost started to arise—and this was my first introduction to behind the scenes, so to speak—but luckily, at no time was I ever responsible for the full cost of my treatment. I come from a middle-class family. I have a brother and a sister, who's also in university, and both my parents work. They're not rich. My mom, who does work for a large bank, has supplementary drug coverage. Unfortunately, we found out how limited that coverage can be, and we were never able to make use of it.

At first, I was only expected to pay for some standard side-effect drugs for nausea, and some of the basic treatment drugs. These are expensive but, relative to the entire treatment, they're fairly cheap. I also had to take another drug, Neupogen, which was covered by the Ontario drug benefit program. A week's treatment of Neupogen costs about \$1,500; obviously, as a student, I can't afford this. While I was with the Scarborough clinic, which is where I was initially treated, I was covered on a monthly basis by the Ontario drug benefit program, but the Scarborough clinic had to continually justify my eligibility. Admittedly, I could have paid more of the costs of my drugs, but realistically it would have been at the expense of my university education.

My family and I were fortunate. I strongly believe the government must reconsider those elements in Bill 26 that shift the burden of drug costs to patients, whether through user fees or the deregulation of drug prices. I should point out that drugs like the Neupogen kept me out of the hospital and healthy enough to go to school, and during seven and a half months of treatment, I only spent one night in hospital, and that was for the biopsies at the very beginning.

So I ask, why can't the government continue to fund these kinds of drugs, which are obviously less expensive than having patients hospitalized?

As I've already told the committee, the care I received as a cancer patient was excellent. In fact, most of the health care providers I came in contact with often pointed out the costs to me for X-rays and blood tests, not to worry me but to make me aware of the entire decision they had to make.

My symptoms and the seriousness of side-effects were always weighed off against medically based factors. The amendments to the Health Insurance Act in Bill 26 redefining what is medically necessary are unnecessary and potentially dangerous, given that the people best equipped to decide, the medical experts, already make those decisions. For the government to restrict what is medically necessary discredits the experience and the judgement of our health care professionals.

As a patient, I enjoyed flexibility with both my treatment schedule and my treatment location. I had access to expertise from more than one oncologist and specialists at two different clinics. Because I'm a university student, this kind of flexibility is very important. For this reason I have concerns about the provisions in Bill

26 which allow Ministry of Health officials to determine where and by whom particular services are performed.

These same provisions are also troublesome from another perspective. While I trust and respect all my doctors, if I ever felt uncomfortable I would not want my right to find a new doctor, or for that matter a different treatment, limited by staff at the Ministry of Health.

Dr Lochrin has stated that cancer is primarily a disease of older people, and obviously I'm an exception. As someone who will likely live a long time after his experience with cancer, I find the provisions under Bill 26 that give the Minister of Health the power to review and share my medical history alarming. I am concerned that people would have access to my medical records and decisions might be made on my behalf without consultation. In short, I'm afraid of discrimination based on the fact that when I was 20 years old I was diagnosed with cancer.

Before I finish, I want to make the point that, as a patient, being well informed provided me with a lot of good healing power. Being empowered with information and with the ability to choose where I am treated, I felt I had responsibility for my own wellbeing, and I believe that contributed to the overall success of my treatment. I do not feel that I was simply at the whim of a monstrous, bureaucratic health system.

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Information, whether it's about the disease, treatment, side effects or nutrition, is critical to a person's treatment. The health care system needs to formalize the role that information sources and volunteer services like the Canadian Cancer Society play. Their largest resource—people—remains largely unrecognized.

As a cancer patient who was "cured" by our health care system, I know first hand the value of what is at stake as the system is restructured. Many of the components in Bill 26 jeopardize this care. The government should reconsider many of its decisions in regard to Bill 26 so that cancer patients, and all patients for that matter, continue to receive the same excellent care that I received.

Thank you very much for your attention.

Ms Ruth Lewkowicz: Good morning, Mr Chairman and members of the committee. I would like to preface my remarks about Bill 26 with a more general reference to the potential contribution of volunteer organizations to the overall efforts of this government.

In taking action to control the deficit, the government has on many occasions suggested that the volunteer sector can and should be utilized to fill the gaps left by its withdrawal from public services. This is misleading and unacceptable, especially in the area of health care.

The Canadian Cancer Society will continue our fund-raising efforts to provide \$40 million worth of cancer research and patient services each year, but the Canadian Cancer Society cannot and will not be a substitute provider of medically necessary services.

The government must keep its commitment to maintaining our publicly funded health care system. However, in the unfortunate event that it does not fulfil this responsibility, the Canadian Cancer Society insists, and the

public deserves, that the government be prepared to account for its decisions.

The health provisions of Bill 26 are numerous and complex. Like Alex, I will focus on those issues that directly affect the quality of care for people living with cancer and people at risk of developing cancer.

Amendments to the Public Hospitals Act, the Ministry of Health Act and the Private Hospitals Act give the minister exclusive power to fund, close and merge hospitals and to decide the type and volume of services that hospitals will provide. These amendments are excessive and give rise to problems in both the process and substance of hospital restructuring.

In terms of process, hospitals are public institutions, accountable through their volunteer boards of directors. Given this government's position on the importance of volunteers, it's difficult to understand why it's prepared to exclude volunteers from the important process of hospital restructuring. These provisions imply that hospital boards are not capable of responsible management or that they care little about the financial viability of their institutions.

Second, it removes indispensable local knowledge and expertise from the reform process. The creation of the Health Services Restructuring Commission poses similar problems by usurping the role of district health councils.

The government's restructuring model must include a formalized role for local participation to ensure that local patient needs are appropriately met within the network of existing and planned community services.

Bill 26 gives the government the authority to move quickly to rationalize hospital services, but this does not adequately address the corresponding need for care in the community. Such services must be in place before rationalization occurs. We already know that existing community services are inadequate. The requests for help that come to the Canadian Cancer Society tell us that the demand for us to top up the government's homemaking services will only increase.

We are especially concerned about hospital restructuring occurring in the absence of the support required for long-term care reform. As Dr Lochrin stated, cancer is a disease primarily of older people. To assume that seniors have relatives to rely on is faulty. To assume that community care is provided by friends and families is totally unrealistic. Both assumptions are out of date, and in rural centres for that matter. For government action to be progressive, it should be based on the realities of today as well as future expectations.

The Chair: May I interrupt you for just a minute? I just want to let you know you've got about six minutes left, just to make you aware of that. Whether you want to leave any time for questions or finish is your choice.

Ms Lewkowicz: I'll just make a few more points.

The Canadian Cancer Society has serious concerns about using the Independent Health Facilities Act as amended to build up community services. Because the amendments allow private, for-profit ownership, and because the minister and the general manager of OHIP would have the power under the act to list and delist medically necessary services, we are very concerned that

the Independent Health Facilities Act will serve as a way to get around the Canada Health Act.

The result will surely be the creation of a two-tiered health care system in Ontario. The amendments to the Health Care Accessibility Act allowing the cabinet to set user fees for services currently covered by OHIP underscore this concern. Such changes are simply not acceptable.

Let's look at this in the context of providing chemotherapy because of its importance to so many cancer patients. Right now, chemotherapy provided in a hospital or regional cancer centre is covered through the institution's global budget. Because chemotherapy is essentially a drug, it's not an insured OHIP service. In many cases, chemotherapy is an outpatient treatment that can be provided in community facilities. Nowhere in the Independent Health Facilities Act does it explicitly guarantee that chemotherapy would continue to be covered by the public health care system outside of the hospital.

Even if the chemotherapy itself is covered, the fact that drugs are not insured services could allow for patients to be charged the cost of administering the treatment. Indeed, the wording of the act as it now stands appears to permit operators of these independent health facilities to charge patients a facility fee. Given the importance of pharmacological treatments, not only for cancer patients but really for all disease groups, the government must move immediately to address the problem.

First of all, the government must assure that the costs of drugs, as well as the costs associated with administering drugs in community facilities, are provided through the public health care system. Second, the government must guarantee that these services, regardless of whether they are listed on the OHIP schedule of benefits, are afforded the same protection under the Canada Health Act as insured services.

The Canadian Cancer Society is also very concerned about the imposition of a \$2 fee for prescriptions for individuals with incomes under \$16,000. We know that 20% of people over the age of 65 live at or below Statistics Canada's low-income level. When you have a diagnosis of cancer, it's unexpected, it produces dramatic change and limits the ability to shift resources. This is especially true for low-income seniors on a fixed income who are already spending at least 55% of their income on basic necessities. We strongly suggest that the government look at flexibility for paying the annual \$100 fee by first of all considering increasing the income level requiring this payment or by spreading it out over the course of a year.

The government has a responsibility to communicate these changes to seniors well in advance so they can plan adequately. As well, the government has to evaluate the impact of these user fees to ensure that ODB recipients are not going without necessary treatment.

For cancer patients not covered by the drug benefit program, the Canadian Cancer Society is very concerned about the government's decision to deregulate the price of drugs. Cancer drugs are already in many cases prohibitively expensive. The premise that deregulation will lead to increased competition and a reduction in drug prices is a fallacy. Purchasing drugs is not like buying a new car

or a new refrigerator, where you can shop around to find the best deal. The government is assuming that sick people have the time and the energy to shop around and therefore will drive down the prices of drugs. But what if the government is wrong? When you're dealing with health care, the stakes are very high and the cost of failure is horrific. We're asking that the government seriously consider dropping the amendments deregulating the pricing of prescription drugs.

Finally, I'd like to talk about the Health Insurance Act and the Health Care Accessibility Act and the unprecedented power given to the minister to view and disclose confidential medical records. These provisions seriously compromise the confidentiality of the practitioner-patient relationship. It could have a negative impact on the practitioner's ability to obtain accurate information from the patient, information that could be crucial in providing appropriate medical care.

The Ministry of Health already has the ability and the authority to review medical records, so with whom exactly does the government want to share confidential information? Is the government planning on privatizing OHIP payments? Is it the first step towards introducing a smart card?

The thought that employers or insurers could potentially have access to health information not authorized by the patient is extremely unsettling. Bill 26 does not offer appropriate safeguards to protect individual privacy.

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Bill 26 also does nothing to address the fact that the public at large has never had a meaningful role in decisions affecting the publicly financed health care system. How would the government propose to continuously gain the views of the public, and how would such views be factored into the policy decisions regarding what treatment is available and under what circumstances it will be administered?

We believe that Bill 26 in its current form is inadequate and unsuitable to deal with the problems confronting our health system. The process and the substance of change that it imposes on patients, providers and the health care system as a whole are far removed from the values held by the Canadian Cancer Society, by people living with cancer and indeed most Ontarians with regard to what we consider our most important social program.

We ask that the government take time and carefully consider all of the submissions to the committee. This is an opportunity for the government to restore respect for the democratic process by amending Bill 26 to include the input of the people that you were elected to serve.

The Chair: Thank you very much for your presentation. We appreciate your interest in the process. Unfortunately, there's no time left for questions.

Mr Robert Chiarelli (Ottawa West): Could I ask for unanimous consent to extend the morning sittings for eight or 10 minutes to enable some questioning of this delegation?

The Chair: Mr Chiarelli, we have been in this process now for about 150 presenters and we have stuck very firmly to the half-hour time line. I think it's fair to all participants that we continue in that process.

COMMUNITY HEALTH CENTRES: OTTAWA AND EASTERN ONTARIO

The Chair: Next is the Sandy Hill Community Health Centre. Good morning and welcome. You have a half-hour to use as you see fit. Should you allow time for questions, they would begin with the New Democrats. The floor is yours. Introduce yourselves so that Hansard can record it, please.

Ms Lois Crowe: My name is Lois Crowe and I'm the president of the Sandy Hill Community Health Centre. On my left is Paul Richard. He's from the Centretown Community Health Centre, and on his left is Cynthia Callard, who is with the Somerset West Community Health Centre. We're all board members. Also with us is Dennise Albrecht, who is the executive director of the Sandy Hill Community Health Centre.

We want to thank you for allowing us to present today. We're going to try and make our presentations brief so that we can get into some dialogue and some questions.

One of the things that community health centres are here for and one of the things that we do is we promote and we are committed to working in partnership with our communities, with our neighbourhoods, with our clients, with the ministry, with everyone. It's a team approach, it's a holistic approach to health.

We offer services, and not just direct health care services. We do have doctors and nurses, but also, depending on the centre, we have social workers, we have seniors' programs, we have community developers, health promoters, and that's part of the approach. It's a team approach to health care.

When we were looking at the presentation today, one of the things that we looked at is, when the Progressive Conservative government came out with documents, we weren't too concerned at first, because the words—if I can just quote first from Jim Wilson, who is obviously the current Minister of Health. This was on May 31, 1995, and he said: "Health care is much more than a line item that eats up space and vast resources in a budget. The trademarks that have built and sustained our system—compassion, caring and excellence—are the same qualities that distinguish us as Canadians."

In the Mike Harris Forum on Bringing Common Sense to Health Care on December 2, 1994, the stated goals in health care of the soon-to-be government were its management and accountability, a health care bill of rights, individual responsibility and fostering community involvement.

Obviously, those are things, as far as community health centres are concerned, that we support 100% fundamentally, and that's where we're coming from as well. However, when you get down to the legislation that's been produced, we don't see those concerns reflected in the bill and that's what we want to speak about. We're going to focus on the health care portion, because that's obviously our area of expertise, and we're going to highlight a little bit.

The main areas of concern are the extensive powers given to the Ministry of Health and the government; defining the Health Services Restructuring Commission; the possible erosion of our non-profit health sector;

decreased accessibility to health services; disclosure of personal information; and higher drug costs. These are the highlights of our concerns.

I want to start off with something simple, which is the Health Services Restructuring Commission. Bill 26 does not define the composition, the role or the responsibilities of this commission. The amendments allow specific members of the commission to act without the direction or the authority of the whole Health Services Restructuring Commission, and the government is insulated from legal liabilities arising from hospital restructuring. These are pretty serious concerns.

We have a number of recommendations and they are listed in our document, but we wanted to really talk about what our concerns are.

The next piece that I want to talk about is one of my own personal concerns: the extensive powers given to the Minister of Health and the government. In various documents, again, the government has said that it believes in individual control, individual participation, consumers' right to control their own health, and yet this bill actually does the opposite. It centralizes power. It doesn't put the power in our hands. It doesn't put the power in the hands of our consumers, our clients, the people we work with.

We represent, just at this table, the nine community health centres that put this presentation together. We have over 60,000 clients, just ourselves, in eastern Ontario, and there are more. We work with all the communities in eastern Ontario, and our whole goal and our whole purpose is to do exactly what the government has said in terms of working with individuals' rights to control their own health care. That's what we do; that's what we want. This bill doesn't allow that to happen. It centralizes the power. There aren't any checks and balances, and that is one of our main areas of concern.

I'm going to pass it over to Paul to continue.

Mr Paul Richard: Thank you, Lois. I will speak to the following two points: erosion of our non-profit health sector and decreased accessibility to health care services.

En termes d'érosion au secteur d'organismes à but non lucratif de santé, je voudrais commenter sur les effets possibles du processus d'appel de proposition pour les services indépendants de la santé tel que présenté dans le projet de loi.

On peut concevoir que de tels pouvoirs excessifs obtenus à travers ce projet de loi pourraient ronger au système de santé que l'on connaît aujourd'hui. Bien que l'approvisionnement de services de qualité ne soit pas une caractéristique exclusive aux organismes canadiens, ces derniers possèdent une orientation conforme aux valeurs canadiennes, tout en reflétant les principes de l'assurance-maladie de la Loi canadienne sur la santé, soit de l'anglais, medicare. On ignore l'impact de l'ouverture du secteur ontarien de la santé aux compagnies étrangères.

En plus de voir une perte possible d'emplois des mains des ontariens et des ontariennes, le résultat de cette ouverture peut aussi dépendre de la manière de laquelle les licences sont accordées aux organismes indépendants de la santé. Nous soutenons donc qu'un processus équitable en ce qui concerne l'allocation de licences à des organismes indépendants de la santé soit développé. De plus, nous recommandons que vous consultiez notre

association provinciale, l'Association des centres de santé de l'Ontario, sur les ramifications potentielles qui découleraient d'une réallocation de ressources en provenance de la restructuration des hôpitaux.

La santé se compare mal à d'autres produits de commerce. Les mesures proposées dans ce projet de loi auront des retombées d'envergure immense. Nous proposons donc de la prudence. Peut-être qu'il y aurait moyen de procéder par incrément dans l'allocation de licences en tenant compte de la diversité de la population ontarienne.

Un exemple d'un processus qui tient compte de la diversité de la population ontarienne serait l'aspect d'accessibilité en tant que déterminant de santé, ce qui m'emmène au deuxième sujet dont je voulais traiter : la réduction d'accessibilité aux services de la santé.

On soutient que le défi que présente l'accès est d'identifier tous les types possibles de barrières aux services et programmes de santé — tels que l'espace, la langue, la culture, l'âge, l'orientation sexuelle, le statut socio-économique, un handicap — et ainsi oeuvrer à éliminer ces barrières. Donc, l'exclusion de certains services de santé de l'assurance-maladie, le recours aux frais modérateurs en plus de la création continue de cliniques à but lucratif contribuent à la création d'un système de santé à plusieurs niveaux.

Grâce à notre rôle dans la communauté, nous connaissons l'effet dissuasif que de tels frais peuvent avoir lorsqu'un client ne possède pas les moyens financiers pour accéder à un service. Remettre un traitement peut mener à la nécessité d'une intervention plus coûteuse plus tard. Doit-on rappeler que l'introduction de frais modérateurs ne modifie pas l'abus du système ?

Voyons à sauvegarder et renforcer les cinq principes d'assurance-maladie sur lesquels repose notre système de santé : l'universalité, l'accessibilité, la transférabilité d'une province ou d'un territoire à l'autre, l'intégralité, et l'administration publique sans but lucratif. Sur ce point, je voudrais laisser la parole à Cynthia.

Ms Cynthia Callard: I want to comment on two aspects of this bill which are of significant concern to those who provide health services and to those who are in need of medical care.

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The first is the serious erosion this bill represents into the privileged and confidential relationship between doctor and patient. Under this law, for the first time, government employees will be able to remove confidential health care records from offices to photocopy them and use them as they wish. Ontario citizens were never asked, nor did we ever agree, to give the government the right to view and use information from our personal files, yet this bill assumes that power.

Our concerns are not only for the breach of privacy and the erosion of established civil liberties. This bill has serious implications for health. How can a doctor ask for or a patient divulge information in response to sensitive questions regarding illegal drug use or sexual orientation or sexual practice or even mental health when they know that the answers to those questions won't be safeguarded, when they know that this law permits the minister to make this information public, when they know that this law permits the information to be shared with any party

the government contracts with, when they don't know if this information is going to become the source of gossip and anecdotes in government offices?

That's why we recommend that this committee delete those sections of the bill which erode any privacy.

There are alternatives available to the government. If they suspect fraud, there are policing provisions with established safeguards and established rules. If they suspect bad administrative practice, the Auditor General's office, which reports to the Legislature, not the government, is capable of investigating and reporting. If they suspect that medically unnecessary treatments are being prescribed, the licensing body for doctors has a mechanism that they can use to inspect. The government can always lay a complaint.

The second issue I wish to raise is that concerning the impact on drug prices. We have every reason to believe that the changes to the Ontario Drug Benefit Act will have a severe impact on people with low incomes, like seniors and welfare recipients, but also, deregulating drug prices will push those prices up. Prescription drugs are already unaffordable to many people; the changes will only worsen this.

Under this bill, the government, not the doctor, will be able to choose which drugs can be used for specific treatments under the Ontario drug benefit plan. If a doctor prescribes a different drug, ODB users will have to pay the difference, and there is a difference. Sometimes generics function differently in the body; there's a medical difference, a physiological difference. Sometimes they function differently on how patients follow a course of treatment.

I'll give you an example. Doxycycline, an antibiotic, must be taken only twice a day. The generic equivalent, tetracycline, is taken four times a day. For a patient with a memory disorder, or for a caregiver of a patient with a memory disorder, this is a significant difference and it can impact on their health treatment. That's why we recommend that this committee retract the drug user fees provisions for members who are low-income seniors or welfare recipients, and we also recommend that this committee recommend that the provincial government maintain its role and responsibility in regulating drug prices.

Ms Crowe: In conclusion, talking about the areas of concern we talked about earlier, I want to highlight some of the recommendations for the committee.

First of all, I want to say again that we are representing nine community health centres, so there's a broad representation and broad input into this report. The three of us at the table were volunteer board members. Obviously, volunteer participation in health care is really important to us. It's something we believe in fundamentally. We want to make sure that in considering changes to this legislation, checks and balances are in place regarding the powers of the government.

We want to make sure that the composition, role and responsibilities of health services restructuring committees and commissions are defined and that accountability is assured.

We want to make sure that the Canadian-owned non-profit health sector is preserved.

We want to build strong partnerships with governments; we're here to work with the government. We do believe that health care reform is necessary. How we do that is where we can discuss things, but we're absolutely in favour of reforming the health care system.

We want to build strong partnerships between governments and local district health councils. They're in place and they're working. Health planning is certainly an area where the government can consult and use the district health councils.

Absolutely and fundamentally, one of the things we believe in is that there be no user fees at any part of the system.

The final point is around the erosion of privacy and confidentiality of personal health information. This is one of the fundamental beliefs of community health centres and around community health planners.

The Chair: We've got about four minutes per party left for questions, beginning with Ms Lankin.

Ms Lankin: When you say that you fundamentally believe in health care reform and restructuring, we know that to be true. The driving force for reallocation of resources from institution to community, from illness treatment to illness prevention and health promotion, has been led by many people in the reform movement but certainly community health centres have been in the forefront of that. I don't think anyone would at all question your commitment to that. In fact, I think you've played a role over the years in trying to get the hospitals to the point where they seem to be at now in acknowledging that the restructuring needs to take place and resources need to move from institution to community.

I am interested in your recommendations around definition of the restructuring commission and linkages to the local health planning process being led by DHCs and others at the community level. We had a representative present this morning from one of the hospitals, from the General, who said: "That community process really isn't working here in Ottawa. Consultation has gone on, but I'm not convinced it's really representatives of the public who've come forward, and we haven't reached a consensus." I think that was the bottom line. He was very supportive of the powers as they are in the bill, without spelling out any linkages to the local process.

I asked him: "If you want the minister then to settle this, because Ottawa can't get its act together and can't get to a consensus," which seemed to be what he was implying, "who is it the minister should listen to? What is it he should decide to impose on the community?" He said, "Well, us." That would be the view of the teaching, high-tech hospital in this area, which has a very important role to play overall, but one part. Do you have any comments on why you think this community consultation process needs to be built into the legislation, reflecting on what you've experienced in Ottawa?

Ms Denise Albrecht: As the executive director of Sandy Hill and someone who has been involved in the restructuring here in Ottawa-Carleton, I would like to respond. The process of Ottawa-Carleton has really been based on its history. It's one of the areas in Ontario that has a very strong, community-based network of organizations that work together, including the hospitals. The

process the district health council has used and has fought for is a very open consultation process, so we don't only hear from key stakeholders who may have a lot to gain or to lose in the process—hospital executives, perhaps even board members from community health centres—but an opportunity to hear from the consumers who benefit or lose from these different changes.

Part of the problem that Ottawa-Carleton has had is that the government has made three significant changes between September and December in its directions to this district health council. That has given an image of a great deal of confusion. In fact, the district health council and the volunteers who staff it and act on all of its committees, who number about 300, as well as the council, have rallied each time: when the time frame was reduced from nine months to three to get consultation to come up with a recommendation; when we fought for having an open consultation process rather than a closed-door, blue-ribbon panel who would just make the decision and impose it; and then in mid-December when finally the time deadline was extended and more money was provided. All those things have caused us to go back and change the work plan of the consultants and all the volunteers.

In a four-day period, we had 30,000 responses to the initial scenarios the council put forward, just on, "Are these the scenarios we should get more information about to cost?" I think that represents the kind of breadth that Ottawa-Carleton is known for, to get the voice of the people from a very diverse range.

1020

Mrs Janet Ecker (Durham West): Thank you very much for taking the time to come today and put forward some excellent suggestions. I have a question, but just quickly, there are some points I believe I can ease your mind on to a certain extent.

The first one is that it's not the government's intention to be forcing CHCs to become independent health facilities. The second point is that the whole restructuring process in this province has been and must continue to be based on the volunteer efforts of those involved on hospital boards and district health councils, because we think that is very important. Certainly, we are not planning on changing that.

The other point is that we are abiding by, and will be abiding by, the Canada Health Act. It is not our intent to get into a pointless and non-productive fight with the federal government over the Canada Health Act.

The other point is that there are now in the independent licensed health facilities, for-profit facilities. They are already there. The important thing about the Independent Health Facilities Act, which many individuals may not be aware of, is that the entire intent of that legislation is about quality, ensuring that regardless of who owns those facilities, regardless of what services they're providing, regardless of where they are, there is quality assurance being done in that facility by the health care team—physicians, nurses and other professionals. That is the process that act brings in.

One of the problems is that in facilities not licensed under that act in Ontario, that are providing services now, there have actually been deaths. One of the things we

want to do with this legislation is to make sure that those quality provisions can be extended to many other facilities.

Another point is that the confidentiality of patient records is a fundamental principle in the system. It was before this legislation, and it will continue to be after this legislation. There will not be patient records being strewn all over the streets, as some people would have you believe, with this legislation.

One of the things we have to deal with is the fact that there is misuse in the system. Seventy per cent of physicians told Maclean's magazine last year that they believe some of their colleagues were unnecessarily using the system and bringing people in, and that they shouldn't be. We also know, for example, if you look at OHIP information, that in one month alone 7,000 patients went to see more than five physicians in one month—general physicians; we're not talking specialists here, people with special health needs. We're saying 7,000 individuals went to see five family doctors within one month. Physicians call that double-doctoring, and they tell us that's a problem.

The only way we're going to be able to get at that is to share information within the system, which is what's happening now for fraud and misuse. You mentioned the College of Physicians and Surgeons and the other regulatory bodies. The CPSO and the MRC looks at fraud and misuse by practitioners. They're telling us that system doesn't work and needs to be changed, because it's taking years and is not being able to get back the money that's been misused by some providers so we can make sure it gets to front-line health care, where it should be.

Would you feel more comfortable if the fraud and misuse provisions, if the college's MRC process, for example, were to be streamlined, were to be made more effective, so that it's the physicians and the public appointees within that process who are making those decisions? Would that make you feel more comfortable with the government trying to deal with misuse by either consumers and/or practitioners?

Ms Collard: I think there is a genuine need and desire of Ontarians to ensure that the health care system is sustainable because it's not misused. That's almost part of the rule of law. We have that in a variety of issues outside of health care as well: We want to make sure our income tax self-reporting system is maintained; we want to make sure crimes are prosecuted. But when the government has set up in the past ways of ensuring that income tax fraud is detected, they limit the powers of the Income Tax Act. For example, any material gained under an income tax investigation cannot be used in a criminal prosecution.

Those types of safeguards are not in this act. Those types of safeguards could be put into it. When they have extensive police powers, they put in a citizens' board which supervises the police, or with CSIS, they have a special review committee. The government is not giving that kind of safeguard, that we see in this bill, anyway. That is something you could add on to it.

Mr Bernard Grandmaitre (Ottawa East): It seems that some members of the government have more information than the opposition, from comments from certain

members of this committee. It seems there should be more consultation, because we need to know more, especially about the freedom of information.

Ma question s'adresse surtout à l'accessibilité des services. Vous avez mentionné tantôt vos inquiétudes concernant l'accessibilité de certains services offerts par les centres de santé communautaires. Alors, pourriez-vous m'expliquer d'avantage ou amplifier d'avantage sur vos inquiétudes concernant les services livrés, surtout en français, ou la prestation des services de vos centres communautaires ?

M. Richard : Le point principal, comme vous l'avez mentionné, c'est l'introduction de frais modérateurs pour accéder à un service. C'est donc sur ce point-là qu'on voulait mettre un peu plus d'emphasis, parce que ça peut devenir un déterrent. Si quelqu'un veut accéder à un service et ne peut pas se permettre de défrayer les deux dollars ou quelque chose, il va se passer du service. Donc, c'est tout enchaîné avec le fait que s'il n'a pas son traitement ou qu'il n'est pas vu tout de suite, ça peut amener des coûts supplémentaires dans le futur. Donc, c'est sur ce point-là en particulier qu'on veut l'amener, pour l'accessibilité.

M. Grandmaître : Vous adressez surtout les frais d'utilisateur. Vous êtes absolument contre les frais d'utilisateur pour certains des services que vous offrez. Par contre, si on parle de Sandy Hill, le centre que je connais assez bien, comment est-ce que ce centre sera directement affecté avec les modifications ou les changements apportés par la loi 26 ?

Ms Crowe : You're asking how this bill is going to affect Sandy Hill?

Mr Grandmaître : Yes, directly.

Ms Crowe : One of the things Sandy Hill Community Health Centre does is service a lot of the hard-to-serve population. We're in the centre of town and deal with a lot of homeless people, a lot of people with different kinds of problems in terms of accessing health services. In fact, one of the reasons we set up our walk-in clinics is to deal with people who would never have access to a doctor otherwise, because they wouldn't feel comfortable. We have outreach workers who go and work with this population as well.

One effect of some of the changes we're already seeing is increased demand. We cannot take on any more health services clients; we're at our maximum. The provisions in this bill and provisions in some of the other legislation—we're seeing an increase in the demands on the high end, the more intensive-need end of services. It's having a tremendous effect. Maybe Dennise can add to that.

Ms Albrecht : What Sandy Hill and the other community health centres are more interested in is the improving of the health status of the populations we serve, as opposed to just provision of service. Having that emphasis means we look at very broad issues: determinants of health, things that make people unwell. This bill taps on to a lot of those things. By taking away opportunities for people to be increasingly involved in decisions, not only in health care but all across their community—which is a very basic democratic right, a factor that really builds

strong and vibrant and healthy communities—that impacts on us as well as some of the more direct service issues.

We talked about a qualitative care system that we have in Ontario, and we do. Many of us believe that is primarily because the base of that is Canadian-owned and non-profit. There is a very strong role for for-profit organizations but within a non-profit overall sector. For us, the erosion of that would affect the health status of the community.

The Chair : Thank you very much, folks. We appreciate your presentation and your interest in our process. Have a good day.

1030

Ms Lankin : Mr Chair, may I place a motion before the committee, please. My motion reads as follows:

Whereas there has been overwhelming public interest in Bill 26 and that 59 groups and individuals have requested to appear today here before the standing committee on general government in Ottawa, which far exceeds the 15 spaces available today for hearings;

I move that the committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged for the community of Ottawa.

Further, that this committee recommends that the three House leaders meet as soon as possible to discuss this issue.

The Chair : Thank you, Ms Lankin. As we have done in other communities where a similar motion has been presented, I've asked for unanimous consent to discuss it at lunchtime rather than to impact on presenters who are here and have it impact on their time. Do I have unanimous consent for that?

Mrs McLeod : Mr Chairman, if I may just make a comment on that. We have agreed to that since I think we all recognize the importance of bringing forward this resolution every day with the government's resistance to voting on it. Unfortunately, when we do debate this at noon and vote on it at noon, it doesn't give people who are present the opportunity to see the very clear indication that the government is determined to pass this bill. Nevertheless, I recognize that in the interest of having the presenters make their presentations, we should follow the same format again.

But I do think it's important for those who are here to understand that—

The Chair : Are we or are we not going to defer this till lunchtime?

Mrs McLeod : I'm prepared to lend unanimous consent, but Mr Chairman, I want to add another point of information which is new to this committee, and that's the fact that when people see the number of opposition members at the table, they might wonder why we can't be successful in passing a resolution we support.

The Chair : Okay.

Mrs McLeod : It's because, as you know, only one member of the Liberal caucus present at the table actually has a voting right.

The Chair : Good point. Do we have unanimous consent to defer it till lunchtime? Agreed.

ROYAL OTTAWA HEALTH CARE GROUP

The Chair: Our next presenter is the Royal Ottawa Health Care Group, represented by Dr John Atkinson, the vice-chair, Mr Kevin Lamarque, the trustee, and Mr George Langill, executive director. I obviously missed one. Could I ask you all to identify yourselves for Hansard? Welcome to our committee. You have a half-hour. Questions, should you leave time for them, would begin with the government.

Dr John Atkinson: Thank you very much, Mr Chairman. I'm Dr John Atkinson, vice-chair of the Royal Ottawa Health Care Group. On my left is Mr George Langill, who is the president and CEO of the health care group. On my immediate right is Rick Bertrand, our chair, whom we never know quite where he's going to be at any point in time, but he's happily with us today, and finally on my far right is Kevin Lamarque, who is a member of our board.

We welcome the opportunity to meet with this panel today. We have a brief presentation and hopefully we'll leave time for questions because we're interested in that. I will start with an opening introduction as to the roles and activities of the Royal Ottawa Health Care Group. Mr Langill will speak to some specific recommendations and we have a small wrapup.

As representatives of the Royal Ottawa Health Care Group, we are pleased to appear before the general government committee as you undertake hearings on Bill 26, the Savings and Restructuring Act. We believe that Bill 26 has enormous implications for the health care system in Ontario and we are before you today to give our support to the recommendations put forward by the Ontario Hospital Association, support which I believe is generally accepted by the other health facilities in Ottawa.

We are also here speaking to you today not only as hospital representatives but more importantly as representatives and advocates for two very special population groups within the Ottawa-Carleton region: those with mental health illness problems and people with physical disabilities.

The Royal Ottawa Health Care Group operates two hospitals at different sites: the Royal Ottawa Hospital which offers health care services in mental health at its site on Carling Avenue, and the Rehabilitation Centre which provides specialized services in physical medicine and rehabilitation. Each is the major institution of its kind in eastern Ontario, providing comprehensive health care to individuals with physical disabilities and mental illnesses. Both are fully accredited teaching hospitals that provide bilingual services to the residents of the national capital region and beyond.

Through our main divisions and their satellite operations, the Royal Ottawa Health Care Group's services aim to help clients reach their highest level of physical, mental and vocational abilities. Our goal is to meet our clients' needs to the best of our ability. We have a highly professional group that is well-integrated, holistic and in fact has very good relationships with community agencies, some of which have presented here today. We provide counselling to help clients become as independent

as possible. We meet those goals through our treatment programs, which are integrated with community agencies in many ways, research, education and advocacy on behalf of our patients and in partnership with the community.

The Royal Ottawa Health Care Group also operates several community-based and outreach services such as a transitional living centre for people with head injuries, a mobile rehabilitation clinic serving eastern and north-eastern Ontario, a service designed for individuals exploring return to work after illness or injury, a drug and alcohol rehabilitation centre and a range of rehabilitation services aimed at the workplace. So you can see we extend far beyond the walls of our facilities. Many of our programs are recognized internationally and nationally as model programs for service delivery, education and research. We have a long-standing track record of responsible fiscal management.

For more than 85 years we have worked closely with community groups and individuals to represent and support the distinct needs of individuals with physical disabilities and mental illnesses. This long tradition as full partners and advocates brings us here today to comment on relevant aspects of Bill 26.

At the outset, we would like to reinforce that we are in full agreement with the recommendations on Bill 26 that have been put forward by the Ontario Hospital Association. Again, I believe there is general support for those recommendations within the Ottawa-Carleton region. We participated with the Ontario hospitals in mapping out the OHA position. Like the OHA, we believe that an unprecedented piece of legislation can be made to work only if the government is willing to make amendments in order to make the bill more palatable and feasible. There are aspects of Bill 26 that are most welcome, including those clauses covering new ways to enhance revenues, recognition of ability to pay in labour disputes and changes to speedy implementation of hospital bylaws, to name a few.

As advocates for the mentally ill and physically disabled, we would like to comment on four areas of the bill which affect or could affect our clients. I'll ask Mr Langill to speak to those.

Mr George Langill: Thank you, John, and thank you, Mr Chairman, for the opportunity.

We would like to present these four items to you as follows, and these are in no order of priority. Our first concern is access to medical records including their ownership, custody, use and disclosure. The current Mental Health Act of Ontario has special provisions relating to this subject. This recognizes the increased sensitivity of clinical information when treating persons with mental illness. Bill 26 proposes increased powers of access to clinical records. There are sections such as in schedule F, part II, of the amendments to the Public Hospitals Act, subsection 13(3), subclause 32(1)(t)(iv) of the act, as well as schedule H, part I of the amendments to the Health Insurance Act and Health Care Accessibility Act, sections 2 and 21, that allude to this in greater detail.

In our opinion, to further liberalize or even appear to liberalize access to such information generally, and

particularly in regard to psychiatric patients, will not only impact the quality of clinical reporting but ultimately the quality of clinical care.

It is therefore our recommendation that the Mental Health Act must continue to take precedence over other legislation in respect to access to clinical information for psychiatric patients.

If I was to put this in more general terms, having heard the discussion this morning, first of all, I think we're encouraged by the comments that have been made around clinical information and confidentiality, but we believe again it's important to emphasize that the standards and practices established by the current Public Hospitals Act, and in particular the Mental Health Act, should be the minimum standard upon which the government builds in respect to any aspects of access to information, clinical information in particular.

The second point we would like to make is the issue of strong advocacy continuing for the vulnerable populations that our institution serves. Provisions under schedule F involving the restructuring of services, and particularly the restructuring commission, that could affect persons with mental illness or physical disabilities, must and should take into consideration the need for strong advocacy methods, particularly when these specialized services might be considered for restructuring, for example, with other larger, more acute medical services.

1040

History has shown that when larger, acute-oriented services are left to set priorities for the needs of these two populations, these populations are often marginalized. I stop at this point and say the reason our organization in fact exists is in some ways a reflection of that and the needs in that regard. The government has recognized this recently in our operating plans, where special provisions have had to be put in by the government to protect schedule 1 psychiatric beds from undue cuts by general hospitals, to name examples of this.

This could also apply to physician service action plans in the proposed legislative package, which for example propose powers to restrict the OHIP fee schedule. We would urge that any move to further restrict OHIP fee schedules must avoid the tendency to define essential services solely along lifesaving as opposed to quality-of-life considerations.

For example, physical rehabilitation medicine offers services which enhance the quality of life, including opportunities to return to work. Rehabilitation is a clear investment rather than an expenditure of health care dollars. It is known that over 80% of people receiving rehabilitation services for serious disability return to their homes, work, schools or active retirement. Furthermore, studies out of the US predominantly indicate that for every \$1 spent on medical rehabilitation, \$7 to \$10 is saved in health care costs.

We therefore recommend that the unilateral and equitable treatment of all hospitals and health care services as proposed must recognize there are vulnerable populations whose needs may be marginalized through broader decisions involving hospital restructuring. We urge the government to ensure appropriate protection and mechanisms are established to prevent such occurrences.

Again, this may well be part of the more detailed discussion that will have to take place in terms of the restructuring commission itself as it begins its very difficult work.

Thirdly, we talk about interministerial coordination. The legislation does not address the serious question of coordination of health services falling outside the responsibility of the Ministry of Health. The most obvious example is mental health for children. In areas such as Ottawa-Carleton, responsibility for children's mental health is fragmented between the Ministry of Health and the Ministry of Community and Social Services, both of which have separate funding and planning responsibilities that are often not integrated around the delivery of services, and are often duplicated, in fact.

As a result of a 1977 decision by the government of Ontario, children's mental health services were placed under the jurisdiction of the Ministry of Community and Social Services. The major priorities of this ministry, as you know, are in social welfare and social services. This has led to gaps in planning, development and provision of health care services directed to the family, particularly as they relate to mental health services.

We allude in our presentation to some statistics that I will leave with you that show the very pressing need in this area that has been presented to the government in studies done by Dr Dan Offer and others in this province.

We feel the government of Ontario should use the opportunity of Bill 26 to address such serious concerns in the province which largely have their roots in a fragmented approach to ministerial responsibility. Using this example, the objective would be to have children accorded at least the same quality of mental health services as the adult population, where the treatment can be in the context of the whole family, not the child or adolescent in isolation.

As the legislation proposes to address fragmentation and coordination of service delivery, we recommend you give equal weight to reducing ministerial fragmentation on vital health delivery issues, such as the funding, planning and delivery of children's mental health care services and return responsibility of such health care services to the Ministry of Health.

Our last point relates to the health care continuum. Bill 26 deals largely with the restructuring of health services, but explicitly or mainly with the hospital component. In both psychiatry and physical rehabilitation there are many service components which fall outside the hospital sector, the community health centres that presented before us, many community mental health agencies, and home care, just to name a few. These are nevertheless integral parts of the system of service delivery. This legislation therefore deals with only part of the health care challenge by virtually ignoring the broader system of community services which remain largely fragmented into numerous small to medium-sized organizations with their own self-contained governments and administrative structures. It is our recommendation that restructuring of health care services should be broadened to include all components of the health care continuum, including community-based health care services. Perhaps, as a word of qualification,

the emphasis has to be equally on all components on the continuum of service, not just the hospital component.

Dr Atkinson: In summary, we have these four recommendations placed before you, as well as our support for the recommendations to the Ontario Hospital Association:

—That the Mental Health Act must continue to take precedence over other legislation in respect to access to clinical information for psychiatric patients;

—That unilateral and equitable treatment of all hospital and health care services, as proposed, must recognize that there are vulnerable populations whose needs may be marginalized through broader decisions involving hospital restructuring. We urge the government to ensure appropriate protection and mechanisms are established to prevent such occurrences;

—That, as the legislation proposes to address fragmentation and coordination of service delivery, we recommend that it give equal weight to reducing interministerial fragmentation on vital health delivery issues such as the funding, planning and delivery of children's mental health care services and return responsibility for such health care services to the Ministry of Health; and finally

—That restructuring of health care services should be broadened to include all components of the health care continuum, including community-based health services.

We're pleased to answer questions and we note that you robbed us of three minutes of our time.

The Chair: We've got about five minutes per party for questions, beginning with the government.

Mrs Helen Johns (Huron): I'd like to thank you for your presentation today and the time you've obviously put into it. One of the issues I have been directly involved in is this issue of children's mental health and where it should be allocated. Children's Mental Health has made presentations both to me as a representative of the Minister of Health and I think to the Ministry of Community and Social Services. It's definitely an area that requires some thinking about, because I know that there's in some ways falling through the cracks. I appreciate you bringing us this again, and we will certainly be looking into that. Thank you very much.

The government recognizes that there has to be an ability to reallocate funds to such important areas as acquired brain injuries. The previous government started the process of trying to bring our people with acquired brain injuries back to Ontario and we have continued on that process. We believe it's a very high priority item: (a) It's financially cost all the taxpayers a lot of money; and (b) people want their family to be close to them. So it's a very important area.

I believe that part of this bill allows us to do that by giving us the ability to reallocate funds within the health care system so that we can put it to specific areas that the community requires or believes is important. I think that's a very good point for you to bring up today.

I was interested in your comments on community involvement. I don't know if you can answer this question for me, but we haven't changed the district health council's mandate or we haven't changed any of its power; is the district health council not meeting the needs of the persons with mental illness or physical disability? As far as we're concerned, the district health council

should be taking into effect everyone's needs. Is that not the case in Ottawa-Carleton?

Dr Atkinson: I think the district health councils function very well in that role. They have had a committee on mental health services for a long period of time. What we've done, as an organization, is to broaden the community involvement. Because we are structured in a programmatic basis and one of our major programs is mental health services, we have a community advisory team consisting of volunteers and people who have had mental health problems that advise the hospital and are represented at the board on health issues. So we've gone beyond the DHC process, which we think is fine, to really bring the community to the health facility and be part of that decision-making process. This has been under way for two years and, from our standpoint, it has been very effective.

Mr Langill: Could I just add too that certainly the reconfiguration exercise that's been alluded to throughout the previous presentations has recognized mental health and rehabilitation as distinct areas that demand concern. I think the reconfiguration emphasis, though, has been more on the acute medical-surgical side to this point.

One thing that I would point out, that we're very pleased with the DHC's position on, is a recognition of a very real anomaly in this community that its major long-term provider of psychiatric services is 125 kilometres away in Brockville. The DHC has recognized that and has asked the government to look into this matter from the point of view of the divestment discussions that are now under way and the need to recognize that we must serve that client group in our communities in Ottawa-Carleton and we must do away with this historical anomaly that has not served them well by being 125 kilometres away from the community they live in.

So we're very pleased with the DHC stance, but I think that's an issue this government's going to have to come to grips with. The DHC has obviously limited powers in that regard.

Mrs Johns: I noticed that you used in your presentation, and not in the document, the quote of either does "liberalize or appear to liberalize" access to specific information when we're talking about access to medical records. Is Tony Clement's personal vendetta—do you agree that it's an appearance as opposed to a reality in the legislation?

1050

Mr Langill: In the absence of being able to give you a definitive yes or no, I think we have to say that we're not sure. We've very encouraged by the comments that have been made this morning, but I think you've got to appreciate, from where we sit, that we're very concerned. In the absence of a statement of some minimum standard, and we see the minimum standard being the current practices that are in place—Mr Labelle earlier on alluded to the fact that the Ottawa General had a good record in this regard. I would suggest they've minimized their risk because they follow the current legislation. So if the government is going to build from there, and we understand they have to, let's state the minimum standard of the current regulations in the Public Hospitals Act and the Mental Health Act, as it involves medical records.

Mr Dalton McGuinty (Ottawa South): Thank you, gentlemen, for your presentation. I wanted to raise with you the issue of this access to medical records and the potential disclosure of hitherto confidential information regarding a psychiatric patient. What gives me particular concern as well is the immunity provision which is found within Bill 26 which effectively provides that if the minister or an agent of the crown acts pursuant to the bill, he or she won't be subject to any liability.

It seems, if you stop to think about it for a minute, that there's something rather perverse here. Here you have a case of government, duly elected, exercising its authority within the framework of a parliamentary democracy—government of the people, by the people, for the people—saying, "By the way, if we do something you don't like, you can't sue us." I mean, talk about biting the hand that voted for you.

What I want you to tell us here today is something about the potential consequences of the release of confidential information regarding a psychiatric patient. There was a presenter here earlier today who talked about the continuing stigma connected with psychiatric illness in our society. Can you describe something of that potential consequence for us, please?

Dr Atkinson: There's no question that in our mental health program we deal with a unique population. It's imperative that these people have confidence that the system is going to protect their records and their need for services in the health system. I don't feel that it's quite as important on the rehabilitation side, which has more of a public acceptance of these problems. They don't have any kind of grey cover over them. So we're quite concerned, as we've reiterated, that the present Mental Health Act, which we feel has served well, continue to function.

In relationship to the lack of an appeal mechanism in any part of the bill as I understand it, I'll speak personally, not as a member of the board: I have grave concerns with that. I don't think that's appropriate. I feel there should be some kind of appeal mechanism. But if we are going to provide the quality of care and if we're going to have the confidence of those patients with acute and chronic mental health problems, then we have to be able to reassure them that their discussions with our providers are confidential.

Mr Langill: May I just add to that, if I have a moment. The client-therapist interaction in mental health is an extremely important one to respect. It's based on trust being established, and that trust is often on the basis of the perception of the clients to the information that they're providing, which is highly sensitive. They're spilling their guts out to the therapist.

The effectiveness of our care there is largely dependent on our ability to ensure privacy. When anything appears to even threaten that, what you end up getting is therapists who will duplicate record systems, who will under-report, and then that becomes a real inherent risk to the patient, who may show up at our emergency and be treated on a medical record that in fact is deficient.

Those are things that we're concerned about. Again, we've been given some assurances, I think, that the government is also concerned about those sorts of things.

Mrs McLeod: That's exactly the point I wanted to make. The point that you've just raised is the one we've heard repeatedly at the hearings, and that's a tremendous concern about the violation of the trust relationship and the reluctance of patients to share information with their caregiver because of the danger of disclosure of information.

Like you, we had received some reassurances first of all from the Minister of Health saying that some amendments would be made to this. We've had that reassurance from time to time from members of the government, but we've also had, I must tell you, Mr Clement's repeated attempts—I think Ms Johns referred to it as the vendetta—to try and say there's nothing wrong with these provisions in the act, in spite of the privacy commissioner very clearly saying that this act, as presented, holds grave consequences for the privacy of any individual.

We want to see the amendments now that the government says it's going to bring in so that we don't have to keep raising this as an alarm if we can take reassurance from those amendments. I think, if we have time, Mr Chiarelli has a question.

The Chair: I'm sorry. Ms Lankin.

Ms Lankin: I'll just follow up with a comment on that. In fact, yesterday we provided the government with an opportunity. Mrs Johns, who is the parliamentary assistant to the Minister of Health, has on a number of occasions before this committee reassured presenters that in fact the government was going to amend the provisions with respect to health care information privacy. We afforded her with an opportunity to inform us whether those amendments would be in accordance with the recommendations of the privacy commissioner, who is the utmost expert on these issues and who has made a set of recommendations of what would satisfy the concerns. We failed to get that commitment from the government. We could go on and talk about a lot of other things if we could get that issue out of the way. We have yet to have any clarification.

That brings me to another point where you may want to get some kind of commitment from Mrs Johns while you're here today. You spoke about the desire to see some rationalization of services interministerially and bringing some of the children's mental health services from Comsoc over into the Ministry of Health. Let me share with you a rumour that is rampant in the two ministries, at this point in time, which is that the welfare income support portion of the Ministry of Community and Social Services will in fact be moved to the Ministry of Finance, and that the social service section and children's mental health service section of the Ministry of Community and Social Services will in fact be moved to the Ministry of Health, and that Comsoc as we know it now will be done away with. That's interesting.

The one assurance I would ask you to try and get for yourselves is that as the budgets are split up, the budget that goes over to the Ministry of Health is not what the government uses to meet its commitment of sealing the Health budget at \$17.4 billion. As you know, they've just made \$1.5 billion in cuts from that budget. They say that they will restore it to the \$17.4 billion by the time they go back to the polls and face the electorate. The rumours

inside the ministries are that this will be supplemented by money that is currently being expended on children's mental health services, bringing it over, which means cuts for everybody in that sense. So that's an area that I think it would behoove you to follow up with government as you're lobbying for these changes.

The specific question I wanted to ask you is with respect to the concerns you've raised around services for vulnerable populations as we go through the restructuring. You've recognized that at local levels there are committees and reports that are looking at how to protect those services locally. But you urged the government to ensure that appropriate protection in mechanisms is established to prevent such occurrences as when we saw general hospitals starting to cut back on schedule 1 psychiatric beds with the strain on their budget and the rationalization of services they had to go through. Have you thought through what protections or what mechanisms are necessary, how they would work, and are there any that we should try to see reflected in the bill through some amendments?

Dr Atkinson: I can answer this with some passion. I believe that the restructuring process that is going on in Ottawa-Carleton at this point is really designed around the adult, medical-surgical side of things, that this is where the savings should be identified and should be achieved. I'm not saying that as a protector of the ROH, because other studies, in fact the Toronto study, supported a network for mental health services and rehabilitation and said that resources should be put in there.

If you move into regional structure, where unsexy programs like rehabilitation and mental health compete with such things as children's programs or cardiac surgery, we get suckered every time. We don't want to see that happen. So we want to have some kind of protection to recognize that those two growing areas, worldwide, in health needs, mental health and rehabilitation, don't fall into a great juggernaut where they will be competing with attractive things like those things which save lives. We've commented that quality of life is every bit as important in the minds of many as saving lives, and indeed in some circumstances is more desirable. So that's our real concern. We don't want to be thrown into the hopper and have to compete that way. We feel that these services are recognized worldwide and there should be some kind of acknowledgement of that.

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The Chair: Thank you, gentlemen. We appreciate your being here and your involvement in our process.

Dr Atkinson: You didn't give me my three minutes.

The Chair: Came awful close.

Mr Chiarelli: On a point of information, Mr Chair: Mr Langill mentioned that he had provided some background material and statistics which I don't believe were distributed to the committee members. I wonder if you could ask the clerk to make that available.

The Chair: It's in the presentation, I believe.

Mr Chiarelli: Dr Offer's material?

Mr Langill: It's alluded to on pages 7 and 8.

Mr Chiarelli: Okay. I thought you said there was additional material which hadn't been presented.

Mr Langill: No, I just didn't read it.

The Chair: Thank you very much.

The hotel has kindly given us a little freebie here and provided us with some extra sitting room next door, so anybody who wants a seat, please avail yourself of that facility. Our thanks to the Delta Hotel for doing that.

Mrs McLeod: Mr Chairman, can I note this is the third day in a row when we've had to request extra seating. Perhaps as we look towards next week's hearings, we might plan for a larger public response than the committee had anticipated.

The Chair: We will pass that on to the clerk.

OTTAWA AND DISTRICT LABOUR COUNCIL

The Chair: The next group is the Ottawa and District Labour Council. Good morning and welcome to our committee. You have a half-hour to use as you see fit. Questions will begin with the Liberals, should you allow time for them, and the floor is yours.

Ms Naomi Gadbois: Thank you very much. My name is Naomi Gadbois. I'm proud to participate on behalf of the 34,000 members of the Ottawa and District Labour Council at these hearings on Bill 26, the Savings and Restructuring Act.

From the outset, the labour council and our affiliates would like to express our profound opposition to both the contents of this bill and the anti-democratic process with which the current government is forcing it upon the citizens of Ontario. The short notice of this hearing date and the exclusion of many groups from Ottawa who requested time with this committee violates all democratic sensibility. Had it not been for the civil disobedience tactics employed by both opposition parties on the floor of the Legislature to protect the normal and democratic process, we would not be before you today, as the Harris government was planning on ramming through another piece of highly regressive legislation without consultation or debate. We congratulate the opposition members both on this committee and in the House for taking such a stand.

This piece of legislation has the ability to create three completely new acts, totally repeal two acts and amend 44 other acts. To clearly understand the impact of this bill, one would have to review over 2,000 pages of text. I will suggest to you today that on the day this legislation was introduced, very few, if any, MPPs had taken the time or had the opportunity to do just that. I will also submit to you today that very few, if any, MPPs to date have taken the opportunity to closely examine all the changes to the 47 acts affected by this one piece of legislation.

At no other time in the history of this province have we seen a government so committed to the destruction of democracy. At no other time in its history have we seen a government so committed to undermining the health of its citizens. At no other time in this province's history have we seen a government so committed to robbing from the poor to give to the rich. At no other time in the history of this province have we seen a government so committed to lining the pockets of pharmaceutical companies and private American health care companies. At no other time in this province's history have we seen

a government so committed to denying the rights of workers. At no other time in the province's history have we seen a government so committed to exposing private medical information while at the same time cutting off public access to public government information. And at no other time in this province's history have we seen a government so committed to destroying this province's history itself.

If this is a history lesson, then let me remind you that the bill you've put before us has only one historical context, and that's wartime. This one piece of legislation dramatically alters 47 acts of law. It seems inconceivable, but it's not unprecedented. The only time when this kind of sweeping change has ever taken place before has been in times of war.

What's the war here for this government? It's a war on the poor and working people in this province. What kind of price do people pay for the war? It would take days, weeks or months before any of us could really get a handle on the scope of this bill. We hardly have the time this morning to scratch the surface of the sweeping, fundamental and irreversible changes that the Harris government is trying to impose on Ontario, but as representatives of the citizens and working people of our community, we'll share with you our initial outrage at specific sections of this bill as it relates to health care.

Under the Canada Health Act, the people of our community have the right to universal, public, non-profit, portable health care. Under Mr Harris's plan it is the insurance companies, drug companies, private hospitals and his government who have all the rights: the right to cut us off when we're too sick or when we're too old; the right to refuse us treatment; the right to decide what medication we can or cannot have; the right to decide what doctor we see, whether or not we get to see a doctor at all etc. This bill is about a fundamental shift in the balance of power around health care.

Bill 26 clearly paves the way for the Americanization of our medical system, and yet our health care is what most Canadians say distinguishes us from Americans. Bill 26 encourages private American companies to open more private health clinics. This will lead directly to a two-tiered health care system, which Ontarians have said again and again they don't want.

Schedule Q of Bill 26 guts labour legislation that protects public sector workers. Because hospital workers are considered essential services, they don't have the right to free collective bargaining with the right to strike. Instead, if agreement isn't reached in collective bargaining, the matter goes to interest arbitration.

The Tories, however, apparently don't trust arbitrators to impose severe pay cuts on public sector workers, so they've changed the rules. Now, under Bill 26, arbitrators must consider the province's economic situation; they must consider the employer's ability to pay. This basically makes a mockery of the arbitration process. The government sets the budget, then says to the arbitrator, "This is all we can afford." The government wins their case, the worker loses, and the integrity of the arbitration process is thrown out the window. Furthermore, this provision places the onus of determining how much workers are paid on the arbitrator, who is supposed to

consider how much services need to be reduced, and takes it off the shoulders of the government.

Arbitrators have responded to these kinds of tactics by concluding that ability to pay is no more than willingness to pay. Public sector workers in our community will be deprived of their right to a fair and impartial process for determining the terms and conditions of employment, rights that are enshrined by the United Nations, the International Labour Organization and our own Canadian Constitution.

Effective January 1, 1997, Bill 26 repeals the proxy provisions of the Pay Equity Act. An estimated 100,000 low-paid women who work in areas such as nursing homes, day cares and shelters, where there are no equivalent male-dominated job classifications, will have their right to fair pay abolished. Many of these women have struggled for years to finally win their 30%, 40%, or even 50% increases. Now they will be granted a measly 3%.

The omnibus bill takes away certain pension rights from Ontario public servants whose jobs are about to be eliminated by the Tories. Could it be that as the Harris government plans to lay off as many as 20,000 government employees, it plans to add insult to injury by cheating its employees out of \$400 million to \$500 million worth of pension money owed to them? That is a direct attack on the working men and women of this province. It is theft.

Bill 26 encourages privatization and contracting out of services. At the same time, it denies existing employees successor rights so that the decent paying jobs of qualified workers can be replaced by poorly paid, under-qualified, non-union staff. Long-time unionized employees will lose their seniority, wages and jobs without successor rights protection. This will hurt workers in the Ottawa-Carleton region, it will hurt our economy as downward pressure is put on wages, and it will undoubtedly threaten the quality of patient care for citizens in Ottawa-Carleton as they are handed over to less qualified personnel.

If Bill 26 goes through, Ontario will be the only province that doesn't protect its citizens from soaring drug prices. Bill 26 so dramatically alters the listing and costing of drugs in this province that they've replaced its name, Prescription Drug Cost Regulation Act, with the Drug Interchangeability and Dispensing Fee Act, since it no longer regulates costs. Manufacturers are now free to determine the price for drugs, and under the patent protection of Bill C-91 the prices are sure to go up. As for citizens of our community who depend on the Ontario drug benefit plan, they will be forced to shop around for the best price for their prescriptions. The government now will only pay for generic drugs, even if the generic drug is not suitable for the individual.

The bill introduces "copayment," which is a slippery word for user fees, on prescriptions. It will hit Ontario drug benefit plan recipients very hard, mainly senior citizens and many mother-led families of disabled children, who have already had their social assistance benefits cut by almost 22%.

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If people in a city like ours can't afford prescription drugs—and many already can't—and if drug costs are no

longer regulated, what then? Do we want a city in which sick and injured people can't get basic medication, people like schizophrenics who require medication to maintain their daily balance? Bill 26 practically promotes rising drug costs. We know enough to realize that this will result in people going without medication. Disease will spread, hospitalization and the demand for crisis intervention will increase, and our overall health costs will go up, not down.

It's laudable that the government wants to save money on drug costs, but why not go after the real issues? Take the federal drug patent legislation that extends drug patents for 20 years. Green Shield estimates that once that piece of legislation was introduced, the average price of new drugs increased 93% between 1987 and 1993. If the Harris government was really intent on saving health care dollars, it would go after the feds to repeal this legislation. Instead, they are making the situation even worse by repealing the only provincial legislation we have that effectively controls the cost of drugs. Or they would go after the overprescribing of drugs or tax the ridiculously high profits already being made by transnational drug companies.

The real deficit that people in Ontario should be worried about is the democracy deficit. When the government puts forward legislation that wipes out the ability of people to have a say in their local affairs, we have to wonder seriously whether this government has any commitment whatsoever to democratic principles.

Bill 26 is essentially about expanding the powers of the provincial government. Throughout, the bill gives cabinet or ministers exclusive power to make regulations or to issue directives that would override existing contractual arrangements, thus rendering binding agreements void, while putting in place provisions to ensure that they aren't liable for breaking these agreements.

The sweeping powers outlined in schedule M of Bill 26 amend the Municipal Act to give the government authority to amalgamate, restructure or dissolve all or part of a municipality if they receive a proposal to do so or if they deem it necessary as a result of their restructuring process, and they can do this with little or no provision for public input. They can also contract out or privatize municipal utilities and clear the way for a whole host of new municipal user fees, again with no public input.

Traditionally, changes of this nature require the municipality to hold a referendum, but Bill 26 eliminates this requirement. Why are they so afraid of the will of the people that they're cutting off communication? Apparently it's not important to this government what the people think about where they live or what services they depend on. If there's no requirement to hold municipal referenda, will the Tories just sell off our services to friends? Will it mean that services which don't make money are abandoned, services like hospitals and quality-care public nursing homes? The Harris government has promised to hold referenda, however, in any city that wants a casino. It's too bad we don't have the same options around hospitals.

Bill 26 will effectively muzzle the municipal politicians who may oppose restructuring in their community. Unlike the provincial government, they can be held

personally liable if the municipality is deemed to be adversely affected financially by their refusal to comply with the government's regulations. Municipal councillors will be forced to either swim in the right-wing current or, along with their constituents, pay a heavy price for going against the tide.

Bill 26 gives the Minister of Health virtually unlimited power to dictate every detail of hospitals, including their funding, operation, closure and amalgamation. The minister can also appoint a supervisor to take over hospitals or tell individual hospitals what services they can or cannot provide. Should the hospital's community board of directors oppose any move by a supervisor, the board can be overruled, replaced or simply removed by the supervisor. The bill also gives the minister the power to make any other direction related to the hospital that he considers to be in the public interest. This makes full privatization of public services a great deal easier.

The citizens of Ottawa-Carleton are busy debating how hospitals might be amalgamated, how they can save hospitals etc, but this kind of public discussion is of no importance to the Harris government. By giving the Health minister the unilateral authority to close hospitals, local communities are robbed of the right to have their say in their own health care. It would appear that the health care needs of our citizens are not relevant to Mr Harris's plan.

Privatization doesn't mean the costs go away. It means that individual citizens pay for these services privately instead of through their tax bill. Privatization doesn't save money. When Britain privatized its water and sewer utilities, water bills increased by 74% in the first five years alone. Closer to home we have Alberta. Privatized liquor stores in that province have a smaller selection at higher prices. Privatization is about the loss of public accountability, and this bill is about ideology. It's about making money, not cost or care in our communities.

Section 32 of Bill 26 gives the minister the power to regulate the appointment of physicians and gives him potentially unlimited control over the fundamental decisions relating to where physicians work and whether patients have access to their services while in hospital. As for physicians' fees, they lose their contractual rights as bargained by the Ontario Medical Association. Under Bill 26 they will only be able to be paid for services deemed necessary by the government and will not be reimbursed for services the government considers extraneous. Since when does a high school diploma give Mr Harris the authority to determine what is medically necessary?

On that note, it is extremely frightening to see that the bill also makes reference to "prescribed age groups" to determine what services an individual is entitled to. Are we going to see no bypasses after 65? Further, physicians and patients have no right to appeal these decisions.

Bill 26 gives the government powers to determine what is or isn't medically necessary so it can determine what will or will not be paid for out of OHIP, without any public consultation. Whittling down the services insured under the Canada Health Act is simply another route to two-tiered health care. Those who can afford it will buy insurance to cover what the Canada Health Act or OHIP

no longer cover. Transnational companies like Liberty Health are just waiting to move in.

Today in Ontario, the Independent Health Facilities Act requires the government to give preference to non-profit over profit-making facilities when a health clinic is being set up. It also gives preference to Canadian-owned operations over foreign-owned. But if Bill 26 goes through, this will be repealed. Why? To encourage American for-profit companies to take over more of Ontario's health care. That is what the government has in mind, yet it's not holding public hearings across the province to get the go-ahead from the people. Do the people want American-style health care? Every pollster in the country will tell you they don't, and so will almost every citizen.

In addition, Bill 26 allows the Minister of Health to contract with one or more specified persons who want to set up a new health facility. The current law requires a general request for proposals, to be fair to everyone. But Bill 26 takes this away, allowing the Minister of Health to handpick corporations or individuals who will be able to open businesses—health care franchises—that charge people money. Perhaps the Minister of Health has a few friends in mind or wants to make some new ones. In any case, the bill also denies those who lose bids the right to an appeal or hearing, and the government is not required to provide any reason for its decisions. It doesn't sound very much like the direct democracy we were hearing about in the election campaign.

Schedule K of Bill 26 seriously limits an individual's right to freedom of information by expanding powers to the head of an institution, the right to refuse access, which will undoubtedly result in major delays for access, coupled with lengthy and costly appeal proceedings. The bill puts in place user fees for requests for information—this is public information—as well as user fees to appeal decisions, fees that could differ from person to person. Bill 26 violates the very intent of legislation on freedom of information, which is for private citizens to be able to obtain information about the government's activities.

As for the disclosure of private medical information, Bill 26 effectively wipes out patient-doctor confidentiality. Now the Health minister would have the power to inspect your medical records and disclose the information. In fact, they don't even have to collect it themselves; they can hand the data over to private, for-profit firms to collect, use and disclose. Furthermore, the Minister of Health can choose to use your private medical information for a whole host of purposes, including providing it to private corporations like your insurance company, like your employer. The privacy commissioner has said he is very concerned about Mike Harris's plan. So are the members of this community.

User fees do not save money. Repeated studies have shown they generally cost more to administer than they bring in in revenue. Their only result, besides reinforcing the ideology, is to limit poor people's access to services, in this case health care and prescription drugs. User fees are a flat tax. Unlike income tax where you pay according to what you earn, user fees require everyone to pay the same amount. To one person this may be a drop in the bucket, to another it may mean their ability to make

the rent. It's quite a choice: "Do I want a roof over my head or do I want medication for my sick kid?" We kid ourselves if we believe this won't be the choice faced by some people in our community. If it ever was, Ottawa's far from fat city these days.

Bill 26 also gives the government the power to charge hospital user fees, which would include accommodation and meals, necessary nursing services, lab tests, X-rays, drugs, the use of operating rooms, obstetrical delivery rooms and emergency room visits. The government has already announced that hospitals will be able to charge daily user fees to those patients in acute-care beds who are awaiting placement in chronic-care facilities or nursing homes. Patients will essentially be penalized because they have been placed on a waiting list for services that are already critically underfunded.

The bill authorizes an administrative fee of up to \$150 which hospitals may charge to patients. This is completely unacceptable. People in this city who are poor, who cannot pay the rent and feed themselves, certainly do not have \$150 if they are hospitalized, especially since living with a marginal income increases the risk of illness and emergency situations.

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Bill 26 brings in user fees for seniors and social assistance recipients under the Ontario Drug Benefit Act. In direct contradiction to Mike Harris's campaign promise, user fees will prevent many lower-income Ontarians from using services which are now universally available. The result will be a wider gulf between the haves and the have-nots.

Mr Harris is likely to say this is not a war on people, it's a war on debt. So why does schedule D of Bill 26 authorize the government to borrow up to \$5.6 billion during this fiscal year from capital public markets, international loan markets and the Canada pension plan for the consolidated revenue fund. Could it be that this is how the Harris government intends to live up to its deficit-reduction targets? Or could it be this is how Mike Harris intends to finance his campaign promise of a 30% tax break? Even if the government is able to introduce its promised tax cut, the savings for most Ontarians will likely be outweighed by the new user fees, and we'll still be \$5.6 billion further in debt.

What's contained in Bill 26 comes as a shock to all of us, and probably also to those who voted for Mr Harris's government. There was no mention of these changes in the so-called Common Sense Revolution, which clearly stated there would be no cuts to health care spending and that under this plan there would be no new user fees. Evidently he lied, big-time.

In the so-called Common Sense Revolution, Mike Harris talked about direct democracy, yet the omnibus bill removes requirements for citizen referenda. He talked of devolving power to the grass roots, yet in certain areas the bill centralizes power to a degree unsurpassed in the history of this province. Indeed, if the power is devolved at all in this bill it is to the corporate world, to drug companies, to for-profit nursing homes, to private clinics, to all those waiting in the wings to privatize public services and to those who profit from illness, disease and disability.

Mike Harris talked about responsible government, yet he had drafted a bill that gives the government vast new powers but also ensures it will not be held liable for any decisions it makes and carries out. Throughout the bill, especially in the health sections, the cabinet, the Minister of Health, hospital supervisors and boards of directors are protected by the legislation against any liability or court challenge. Yet the health care providers and citizens are not given any means to appeal decisions or to provide input in the decision-making process. All these democratic avenues have been removed from the system and Bill 26 deletes all references to district health councils. Mike Harris consistently badgers the poor to take responsibility for themselves and their situations, yet he seeks to shelter himself and his ministers from any responsibility for the situations they create in this province.

Bill 26 must be stopped. If it goes through, it will dramatically change the quality of care in this community and it will destroy this community's ability to determine for itself how we want to live here in Ottawa-Carleton. Bill 26 in a direct contravention of the principles of the Canada Health Act, as it effectively encourages the privatization and corporatization of health care. It's an attack on the elderly, the poor and all those who are most in need of compassion and high-quality care. It permits, and even encourages, extra-billing and entrenches two-tiered medicare. The only winners here are the American health care firms and the multinational drug companies.

But there are lots of losers. First and foremost, they are the citizens of our communities, who will be forced out of the health care system quicker and sicker, who will be denied appropriate types of care when needed, who will be bankrupted by soaring drug costs, user fees and private insurance. They'll be denied physician care by doctors whose contracts have been broken by the government, denied treatment on the basis of age or disability, exposed by lack of doctor-patient confidentiality, and the list goes on.

As for our health care providers who use their skills and care to nurture us back to health, keep us comfortable, fed and clean, help us die peacefully, these workers are being robbed of their pensions, are being denied their basic collective bargaining rights and are losing their jobs.

Nearly 30 years ago, Canadians decided that we wanted to share the burden of illness and injury together, that none of us should have to bear the cost alone, that we would spread our risk and pool our resources. That's what public health care is all about—the citizens of this city and this province and this country all sharing the risk, pooling our resources and being involved in health care decisions.

Bill 26 signals the end of a public commitment to health care. It is a decisive move away from community and towards tight-fisted government control and individualism. It ushers in American-style, two-tiered, for-profit health care that will only serve to widen the growing gap between the haves and have-nots in our community and in this province.

The Ottawa and District Labour Council demands that the government take Bill 26 off the table and stop your

war against the people and communities of Ontario. Thank you very much for your attention.

The Chair: We have one minute per party for questions, and only one minute, Mr Chiarelli.

Mr Chiarelli: I'll be very quick. This basically is an economic War Measures Act, as was the social contract. I think the NDP government recognized there was a serious and real deficit problem—perhaps also a democracy deficit but also a real deficit problem.

You've indicated a lot of pain in Bill 26, but if it were to be taken off the table, how would your labour council address the deficit problem? As I mentioned, we know that the last government took very draconian action with the social contract, recognizing the problem. We now have Bill 26—a different government, a different philosophy—dealing with the deficit problem. How do we deal with that problem and not impact on people and not cause people to have pain?

The Chair: Thank you, Mr Chiarelli. Ms Lankin.

Ms Lankin: In one minute is going to be difficult—for me—to put a question. You've said that in light of the criticisms and concerns you want the bill pulled right off the table. I would argue with you that there are some provisions in the bill that could go forward, that borrowing powers etc are necessary for the government to meet its fiscal obligations. We've suggested that those portions go forward on January 29 and that for the pieces of bigger policy with longer-term implications that don't have an impact on the immediate fiscal agenda we take a bit more time.

I know you're calling for the whole bill to be scrapped, but would you support an approach of that measure? Do you have any comments on that?

Ms Gadbois: Should I answer that question?

The Chair: When there's only a minute, if they don't make it a real short question, they don't give you any time to answer. You can have a short answer to Ms Lankin's question.

Ms Gadbois: I do. I have a short answer to both questions, actually.

The Chair: Only to Ms Lankin, because we're talking seconds here.

Ms Gadbois: Okay. We haven't had a chance to see what parts of the bill your party would consider to be worth keeping. That may be possible.

Our concern here, and I think we've made it clear in our brief, is that there hasn't been enough time. This government has been in place less than six months. Nobody's had a chance to read this thing, basically. In answer to Mr Chiarelli's question—

The Chair: For the government, please. Mr Clement.

Mr Clement: Thank you for your presentation. In the limited time, I just wanted to return to your brief where you said, "When Britain privatized its water and sewer utilities, water bills increased." I might note for the record that was because the British government, in its infinite wisdom, decided to set a floor price for water and utility bills, in effect dictating the price.

You see, that's the problem when government gets involved in micromanaging the marketplace: They tend to overcompensate and these things happen. Wouldn't it be better, where we can guarantee quality in a health-care

sector, to have some market forces, such as in the deregulation of drug prices which might in fact drive prices down rather than up?

Ms Gadbois: Oh, no. Deregulation of drug prices is something the federal government has currently precluded, sir. So—

The Chair: Thank you very much. We appreciate your presentation. Too bad there wasn't any more time for questions, but unfortunately there isn't.

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ACADEMY OF MEDICINE, OTTAWA

The Chair: Our last presenter for the morning is the Academy of Medicine for the city of Ottawa, represented by Dr Bryan Lennox, the president, and Dr Diamond Allidina. Good morning and welcome to our committee. You have a half-hour.

Dr Byron Lemmex: Thank you very much. A slight correction there. My name is Byron Lemmex, and I'm a family physician here in Nepean. I'm president of the Ottawa Academy of Medicine, and beside me is Diamond Allidina, who's our local director on the board of the OMA. As I just finished telling you, I'm president of the Academy of Medicine of Ottawa, which has 579 members. I'm also a delegate to OMA council, which in our area represents over 1,700 physicians.

I also have the honour to represent over 1,650 patients in this region who have signed the local academy petition. This petition, in numbers, was obtained over two weeks from just 52 physician offices. This petition objects to Bill 26 because it cancels the partnership between government and physicians to manage health care on a joint basis. It gives unilateral power to the Minister of Health to reduce services and dictate medical care.

I don't wish to dwell on the subject of how unfair, dictatorial, draconian and unjust this bill is. It certainly is all of these. I wish to promote a partnership between physicians and the government and to offer some insight and propose some solutions to these complex problems.

As a family practitioner, I agree that some hospital services should move to the community. I personally make house calls and do a fair amount of palliative care. It requires a great deal of time and effort to allow a patient to die at home. The splendid work of the Victorian Order of Nurses often goes unrecognized, along with our own Ottawa-Carleton home care program, but repeatedly we are hampered by lack of funds.

Just this November, one of my patients was dying at home from bowel cancer. His bowels were blocked by his cancer and he was dying slowly of his cancer, heart failure and starvation. His final wish was to die at home, but he never really admitted he was dying. He lived five weeks at home, cared for by our nurses and his family. Unfortunately, home care funds ran out very quickly, as did his own personal insurance. For the last two weeks of his life, his wife had to call every morning to home care to see if services were going to be provided.

Please, if sick and elderly patients are removed from the hospital, fund the appropriate community agencies. Dying patients still need the care, whether in the com-

munity or in hospital, and your government should transfer those funds accordingly. I am ready, as other family physicians are, to care for patients at home, provided we have the other health professionals working with us.

The Ottawa-Carleton area is one of many areas undergoing reconfiguration. One concern with Bill 26 is the ability of a Health minister to close a hospital with a stroke of a pen. Our district health council has proposed the closure of two hospitals in its reconfiguration plan. By closing the Grace hospital and the Riverside hospital, over 300 beds will be lost to this area.

I wish to point out the number of beds closed is insignificant when compared to the loss of patient services each of these excellent hospitals provide. The Grace hospital provides over 9,000 patient services. The Riverside hospital provides over 10,000 patient services. These services include breast biopsies, cataract surgery, endoscopic procedures, minor surgery, and almost all, I might add, do not even require one night's stay in hospital. To lose 11 operating rooms and six ICU beds in this region would be a drastic reduction in health care services.

The University of Ottawa medical faculty provides many fine physicians to the people of Ontario each year: 32 family practice residents graduate each year from our university. Three local programs are here in Ottawa, with a satellite program in Sudbury, Ontario.

To force our young doctors to the north is not a solution. The retention rate of the Sudbury program is very high in keeping physicians in the north. It also has been shown that selecting medical students from these areas also promotes physicians to return to their home towns. The OMA has produced an incentive package to promote and retain physicians in these underserved areas. Surely these few ideas are much better than forcing physicians to the north. As a physician who spent four years in Kapuskasing, I know your proposed legislation will drive physicians south, not north.

I have a graph here that shows the increase of physicians leaving Canada to the United States has increased 28% per year since 1988, and this graph ends in 1993. I would hate to imagine what this graph would look like in 1996.

Your proposed method of detecting fraud by physicians and patients is too harsh and unfair. The breach of patient confidentiality by giving the Minister of Health the power to demand a patient's file be on his desk is particularly sensitive in this region. I personally treat members of parliament's families and a few senators, and I don't mean the hockey Senators. If they know a political body can get access to information concerning themselves or their families, I'm afraid they may be reluctant to seek proper medical attention, especially for sensitive social issues. The medical review committee of the College of Physicians and Surgeons of Ontario is already directed by the general manager of OHIP to investigate frauds by patients and physicians. Surely by enhancing this program, which involves doctors investigating doctors, done in their offices and with a chance to appeal, would be more cost-effective and does not breach confidentiality, as your bill does, and is more effective.

Dr Diamond Allidina: Byron has talked to you about some concerns that we have as a physician body in this area. I'm going to talk about certain specifics of the bill that impact the practice of medicine for physicians and their patients.

I'm a psychiatrist in Ottawa. I'm a district director of over 1,700 physicians in this region.

I've heard concerns from family physicians, oncologists, psychiatrists, neurosurgeons and general surgeons. Like me, they're horrified at this bill and its broad-ranging implications for health care.

This is unprecedented in Canada. It will impact on how physicians diagnose, order tests and treat patients. Physicians have been wondering why this bill is intended to grab so much power for the ministry and its bureaucracy and sever a partnership link with the profession. Why does the ministry need such broad-ranging tools?

As we digest this complex bill, and as I talk to my colleagues, one glaring fact presents itself to us: The minister, and this government, with its relevant bureaucracy, needs this power to implement managed care.

Managed care, or, as it is dubbed by the physicians in this area, minimal care, is a concept popularized in the United States of America by their insurance companies, where the bottom line is profitability. It's now being imported to Canada by your government. It sets quotas for tests, services, treatments and referrals for a family physician. It sets limits on how long a patient stays in hospitals, the number of times a patient can see a specialist and the treatments that the specialist can render.

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Let me give you an example. I saw Tony Clement; he probably looks under 30. Supposing he were to go to one of our hospitals around here with chest pains. The GP would not be able to refer him for tests until and unless he surpasses a profile of a symptom complex. After the profile has been surpassed and after the GP has had a fill of his quota of referrals, then and then only can Tony Clement go and see a cardiologist. But the cardiologist is also limited. He can only see the patient after the approval from the insurance company. Having seen it and given the opinion, he can only treat after the approval. Who is the approving agent? A clerk.

As you can see, there is no room for patient-based care or treatment in this milieu. Medicine practised in this climate is not going to be patient-centred.

Let me just walk through some of the schedules that are going to help the government introduce minimal, or managed, care. Let's look at schedule H. This gives the ministry huge new powers to decide whether a particular service was medically necessary or is medically necessary or not. The consequences of this are going to make the doctor very anxious, since he does not know which test, procedure, prescription or referral could also be declared invalid after the fact. Therefore, the physician will demand prior authorization before he does anything or before he carries out any investigation or referral. This will lead to diminished care, longer waiting periods for the patient and, of course, increased bureaucracy for the government.

The other aspect of the schedule gives the ministry unilateral powers to define an insured service and to set

a fee for that service, which could mean setting a fee that is nil. The consequence of this is that treatments can be directed to be given not on medical need, based on any scientific criteria, but on political agenda, social agenda, hearsay, quackery, ideology, at the whim of politicians and bureaucrats. You may be surprised to hear that and think that this cannot happen in Canada. It can and it does.

Let me give you an example. In psychiatry, mentally ill patients are a very vulnerable population and they're extremely vulnerable to any new treatments or any new quack ideas that come out. Well, any politician can make use of it for his or her gain.

I can further illustrate the example by saying one of the treatments that we use in rehabilitation of our patients is called intensive psychoanalytic treatment. Scientific basis shows that this is the only treatment and the most comprehensive treatment in the United States that's employed in looking after functionally ill or some dysfunctionally ill mentally ill patients. It can not only cure patients' symptoms but make them productive as employees or as partners.

In Alberta, two years ago the ministry decided to delist this treatment. What was the reasoning? Patients talk about sexual matters to their psychiatrist—no scientific criteria; that was the reason.

Because the minister and his bureaucracy have the power, they can utilize any reason for any patient, whether it be an AIDS patient, a cancer patient or a heart patient, to decide what could be given to the patient. This is managed care, and it is wrong care.

Since the government is getting into the business of setting fees without the knowledge, expertise and organizational structure to carry out this complex process, it would mean that the government would have to increase its bureaucracy to micromanage this system. This was against the Common Sense Revolution.

As you can see, to deliver managed care à la bureaucracy, it will be necessary to silence the doctors and alienate the profession. This bill does this wonderfully. Schedule I can make all our agreements null and void, destabilize the profession, make us anxious so we keep quiet. There's time to come yet; we have about 10 more days before we are really silenced.

Schedule F ensures that the doctors' silence and their compliance is maintained. This schedule systematically removes fairness and due process for the physician. Physician rights are rescinded, there is no right of appeal and the government insulates itself from any legal action. Further, any medical practice, any office practice can be expropriated and its licence withdrawn. In fact, the physician practice in this province is totally unprotected, with no right of appeal.

Also, the general manager of OHIP may personally determine whether or not an individual physician will be deemed eligible to receive a billing number. Hospital privileges will be solely at the discretion of the administration. The tremendous fallout from this for a specialist or a GP is that if he or she acts too often as a spokesperson for the patient or points out too often the deficiencies in the health care system, his or her fate will be sealed. Of course, this issue often opens up the issue of

abuse by the CEOs. You will hear a little bit about that this afternoon. We, the physicians, would have to agree to be directed just to keep on practising medicine.

The concern that we physicians have is that managed care, à la bureaucracy, would provide inadequate care for the acutely ill, longer waiting time for the appropriate treatment and many patients, especially the borderline patients between illness and health, will just fall through the cracks in the system if they are not assertive enough. The outlook for the elderly and the chronically ill is even more dismal.

This bill destroys the traditional partnership between the physicians and the government in the delivery of health care, provides disincentives for good medical care and restructures how health care is delivered in this province. The impact you have heard from Byron is that it will be hard to keep or attract physicians in this region. A recent survey of departing physicians does not necessarily point to an economic factor; it points to relevant factors like stability, predictability and autonomy in the field of practice.

Let me assure you, especially Mr Clement since he has raised the issue, that the government has had the mandate since it got elected to get the tools to restructure health care service. I attended the health care forum in Ottawa that was chaired by Jim Wilson and Mike Harris, Health Policy Discussions on Health Care in the Conservative Arena, and also looked through the manifesto. There was nothing in your platform when you were being elected that suggested that you were going to bring in Bill 26, to implement it, to restructure the health care system in the province. On the contrary, you talked the opposite. You have had a 180-degree turnaround since you got elected.

I'm urging you, since you do not have the mandate to restructure health care services, you do not have the mandate to close hospital beds, to reduce physician services and ration care, that you go back to the people of Ontario and gain that mandate. You gained the mandate in other areas; you did not gain the mandate in health care services.

Thank you very much indeed. Byron and I will entertain any questions from you.

The Chair: We've got about four minutes per party for questions, beginning with the New Democrats.

Ms Lankin: Thank you for your presentation, doctors. It was very powerful. I want to share with you that we have heard similar concerns from physicians as we have travelled, this week, northern Ontario and before Christmas in Toronto. I sense that the state of morale and the lack of stability in the profession right now is at a crisis point, and I fear for what that means for patient care as we're going through this period as well.

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I have a couple of specific questions; let me start with one that we heard in northeastern and northwestern Ontario. We've been in Timmins, Sudbury and Thunder Bay this week, and this is our first opportunity to come into southeastern Ontario. We've heard that the cancellation of the rebate for malpractice insurance will mean in the north that the practice of obstetrics and certain orthopaedic treatments, surgeries, will virtually evaporate up there, that those services won't be available. I'm

interested if you have any views about what that change is going to mean for services in the Ottawa-Carleton region.

Dr Lemmex: Just this Monday the executive of the academy met and four out of the five hospitals that do obstetrics in the Ottawa-Carleton region had representatives there. They have told me that between these four hospitals there are six obstetricians who are going to stop doing deliveries as a result of the loss of the CMPA rebate. We also know of one orthopaedic surgeon who is going to be leaving as a result of just the turmoil that is going on in the province of Ontario. The neurosurgeons are starting to think very seriously about taking on very difficult cases that are high-risk because the obstetricians, neurosurgeons and orthopaedic surgeons are the highest paying dues payers for the CMPA. So the effect in this community will be quite drastic.

Ms Lankin: Are those services that are currently at appropriate service levels, or are any of these areas already jeopardized in terms of the number of physicians that we have?

Dr Lemmex: Certainly in the Ottawa-Carleton area we have a fair number of obstetricians. The problem is that these people work so hard they limit the number of deliveries they do because they have a life to lead too. Now what's going to happen, with six of their colleagues who are going to stop doing it, the ones who are left are going to be working harder and harder. Their fatigue factor is going to take over and you may find that they're going to start to leave because they can't stand the work pace. It's a cascade.

Mrs Ecker: Thank you, doctors, for coming today and taking the time to share your thoughts and your concerns and make your suggestions. While I certainly respect very much your opinion, Dr Allidina, you will forgive me if I do not share all of what you have said. I would like to point out that the minister will be addressing if the CMPA decision is going to be restricting access, especially in the area of obstetricians. He's going to address that, and I refer you to a recent article in the Medical Post where he explained about doing that, because it is not the intent to do that.

In outlining some of the concerns that you have about Bill 26, I think you've also made a very eloquent case for the problems that are in the system now: that physicians have been leaving since 1988; the fact that you've had difficulty and your patient had difficulty getting home care now. I think one of the reasons why we talked a lot about restructuring during the election—I certainly did in my riding—one of the reasons we talked about the need for it was because individuals like physicians and other health care providers in hospitals told us that it was desperately needed. We've closed 9,000 beds in this province over the last several years, and unfortunately the bricks and mortar haven't followed, which is what one of the hospital administrators mentioned earlier.

The other point: You talked about misuse, abuse and whatever in the system, and I think it's interesting to note that almost two thirds of your colleagues believe that some of their colleagues are encouraging use in the system that's not appropriate; that 64% of the public believes that is the case; that OHIP records would

indicate that, for example, there were 7,000 patients who actually went to five or more GPs in one month, which I think most of us would agree seems to be a tad excessive. I think most people agree that there is a need to get in and address what's happening with the misuse of the system by practitioners and consumers.

You mentioned that the MRC may be a cost-effective way to do that. The college has lobbied very strongly over the last several years that it is not a cost-effective way to do it and wants to change it and streamline and get more authority to do it to make it a more cost-effective way to do it. Given the experience that the academy has had with the complaints mediation process between CPSO and yourself that you've put up, is there a way for the ministry to work with the college further to set up mediation processes, complaints mediation, give them more effectiveness, more powers—streamlining of the MRC process, for example—to try and address misuse in the system in a better, more effective way?

Dr Lemmex: First of all, fraud and the physicians: You're dealing with 0.5% of the profession. You just mentioned there are 7,000 patients who were abusing the system. Nowhere in the legislation do I see where you're going to attack the consumer and say, "You're defrauding the system."

Mrs Ecker: First of all, I'm not attacking anybody in the legislation, but in order—

Dr Lemmex: Other than physicians.

Mrs Ecker: No, no. In order to have information. In order to go after that misuse of the system by anybody, you need the information to do it.

Dr Lemmex: Well, let me answer your question. The academy was involved in a pilot project with the College of Physicians and Surgeons to deal with complaints, and we still and always have done with complaints to physicians from the public. Nothing goes on to the CPSO unless it's a drastic things, such as sexual abuse or so on. We did the pilot project at my telling the members of the academy I felt this was important. We did it, we produced the data, we sent it back to the college. What was happening is the college said: "Hey, this is great. We want to put in a layperson, we want to put in a member of the college. We want to have a branch office." The bureaucracy started to build.

What we do right now is we have mediators who are past presidents of the academy. They go to the patient's home. They sit down, they talk to the patient. They say, "What was the problem you had with this physician?" They go to the physician, they sit down with the physician and say, "This is what the patient says; what's your story?" Then they get together and they say: "All right, how are we going to sort this out? Do you just want an apology? Do you just want it recognized that what you did was wrong, or tell the patient that that was wrong?" Simple, clean, very neat. The college wanted all the bureaucrats involved; we said, "No, thank you."

Mrs McLeod: I appreciate and share your concerns in a number of areas, your concern about the loss not only of hospital beds but of hospital services and whether or not those services are going to be provided in the community. I appreciate your concern about whether government-managed care indeed becomes minimal care, and I

truly believe that those concerns become even greater when the ability to make these kinds of cuts is brought forward, the power to make those cut is given to a government that is driven by a totally unrealistic fiscal agenda.

I think we have to keep recognizing, as you've said, that there was no campaign plan for this fundamental restructuring of health care beyond just hospitals, and this bill is not a bill about restructuring health care. It is a Finance bill and it makes the Minister of Health subservient, as somebody said yesterday, to the Minister of Finance. That's really what we're talking about here, is how to take dollars out of health care.

I also note the point was made repeatedly over the last few days as we travelled in northern Ontario that this bill will make the retention of physicians more difficult, not better. Incidentally, just to put on the record, one of the figures we were given yesterday was that in northern Ontario the family medicine program that trains physicians in the north has a retention rate of 67%. So there are better ways.

The concern that we heard, and you've touched on it again today, is that the billing numbers, the coercive powers of Bill 26, and the ways in which Bill 26 allows the Minister of Health essentially to practise medicine without a licence and get in the way of the practice of medicine by professionals will have a very negative effect on physicians practising in Ontario. I'm wondering if you can touch on a number of ways in which you fear it could get in the way. Is it already having an effect on the day-to-day operations in physicians' offices?

Dr Lemmex: One of the services we offer at the academy is physician availability, where if a new patient moves to Ottawa-Carleton and is looking for a physician, they can call our office and we will give them a list of family physicians in their area and so on. That list is dwindling. There are fewer and fewer family practitioners who are taking new patients.

Also, as I just explained, the complaints department—just in the last two weeks we've had numerous patients calling saying they went to see their doctor to ask for a test and the doctor looked at them and said, "I'm not going to order that test because the government may claw back all the funds that come for providing that test, and I refuse to do that." These patients are calling and they are irate. They want to know why they can't have this test done. The physicians are spending time—there are patients in the waiting room—explaining to them that if they order this test and it's proved unnecessary, that physician will have to fund the cost of that test. The number of calls that we're getting is increasing day by day, and this legislation isn't even enacted yet.

Mr Chiarelli: I just had a point of information. I was just wondering if the Chair, over the noon hour, might put out a couple of phone calls to see whether we can get the local Tories, John Baird and Garry Guzzo, in here to listen to some of these presentations.

The Chair: Thank you very much, doctors. We appreciate you being here today and your interest in our process. Have a good day.

We'll now deal with Ms Lankin's motion. In view of the fact that we've dealt with this before, can we shrink

the time a little bit, Ms Lankin? No. Okay, you have the floor. We agreed, unanimous consent, for five minutes.

Ms Lankin: May we have copies of it circulated, please, before we start, Mr Chair?

The Chair: Do we have unanimous consent for a maximum of one presenter and a maximum of five minutes, with Ms Lankin having the ability to split her time at the beginning and the end? Mr Clement?

Mr Clement: Yes, absolutely.

The Chair: Okay, Ms Lankin, the floor is yours.

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Ms Lankin: Thank you very much, Mr Chair. As you will well know and the members of the committee who have been travelling to all of the centres this week, this is the third successive day that we have had to implore the hotel to make either more space available or more chairs available. We have had crowds come out to listen, to understand what is going on with this legislation beyond anything that this committee expected or that we've ever experienced with other pieces of legislation travelling the province.

The number of groups or individuals who have applied to be heard by the committee, to make a presentation, is unprecedented in its volume. These two weeks alone—forget about what happened before Christmas—when we're travelling outside of Toronto, the two subcommittees that are travelling, there have been over 1,000 groups or individuals who have applied for the fewer than 300 hearing spaces that are available.

I think that one of the things I have heard, as members of the government have argued against this motion, is that somehow we are getting a full range of views presented and that that is sufficient for the committee to be able to get on with the legislators' job which will be, at some point in time, to consider amendments and then to report to the Legislature for consideration of the bill.

I would like to point out to you that this is about our ninth day of hearings—when you think of the Toronto hearings and hearings in Timmins, Sudbury, Thunder Bay and here today in Ottawa—and virtually every day there have been new considerations or new aspects brought up that have been brought to our attention. Yesterday, I was stunned by some of the considerations that the bioethicist who presented before us drew to our attention and there's work to be done to understand that and an opportunity—we need the transcripts before we can start to question other people about those considerations.

Every day there have been new areas and new concerns that have been raised, things that even as familiar as I am now with all of these pages of the health sections at least of this bill, areas that I am still understanding new implications for, and we still have debates about interpretations where Mr Clement, for example, has a particular interpretation that differs very much from the privacy commissioner's, and we will be hearing again from the privacy commissioner trying to sort through some of that.

Today in Ottawa, there were 59, say 60 groups, that applied to appear here. There were only 15 spaces available. We're only hearing a quarter of the groups that wanted to make a presentation. There are all sorts of

professions that are not being heard from and individuals in the public whose views we won't get a chance to hear.

I believe it is very important that, given the extent of this bill, given the breadth of this bill and the depth of the changes, that we provide the time for public input. I've said on a number of occasions that our party is willing to pass on the 29th those pieces that the government absolutely needs for its fiscal agenda. What we would like to have is the opportunity on the bigger policy areas to have more public input and a bit more time to understand the direction that you're going and what it is that you're trying to accomplish.

So I would urge the government members to consider support of this motion today. The numbers just keep getting bigger, community after community, and I hope that you will take a different position.

Mr Clement: I would like to speak against this motion, as I have done so in the previous centres that we have debated this particular issue. I am quite heartened actually by the quality of presentations, by the diversity and multiplicity of views that we have heard. Ottawa-Carleton has been no exception to that.

We have heard from patients and providers and doctors and health officials and labour officials. We are hearing from the Ontario Dental Association, for gosh sakes, after lunch, so from my perspective, this process—and again, I disagree with the premise of Ms Lankin's motion—is a process that is allowing legislators, parliamentarians, acting on behalf of the Legislature, to hear a diversity of viewpoints, to consider those viewpoints in our subsequent deliberations for potential amendments. The minister has already stated on the record that this process is important for the Minister of Health and that we are listening very closely, at least from our side, and I'm sure from the other side, to the potential amendments that will come forward.

Ultimately, this process is a legislative process. I would note once more for the record that both sides of this committee will have heard, by my calculation, over 750 presenters from a variety of backgrounds and that this process allows more time for more public input than any bill in the previous two parliaments.

From my perspective, though, ultimately we as legislators have a duty, have a responsibility, have an obligation to act, to legislate, to consider the viewpoints that we have heard and that are available in written form as well—and last night I did a bit of extra reading from the written briefs—to consider all of those viewpoints and to consider the viewpoints of our constituents and to act.

Quite frankly, this morning yet again we heard from presenters who were quite anxious for the government to proceed with restructuring. They know that the system isn't working in health care, they know that the status quo is not working in health care and that patients are at risk. They are expecting us as legislators to act, to use our talents to act for the benefit of the people of Ontario. I, for one, would like to see us act sooner rather than later, because every month, every day that we delay action costs us, costs the taxpayers, costs patients resources that go to interest on the debt—\$1 million an hour. We spend more than we earn as a government. That means less funds, less resources to hospitals, to palliative

care, to long-term care, to HIV sufferers, to cancer sufferers.

I, for one, cannot condone spending one more minute after January 29 on this piece of legislation. I intend to vote against the motion.

Mr Frank Miclash (Kenora): I'll try to remain calm, cool and collected, only if I'm not provoked.

As Ms Lankin has indicated, we have had a great number of requests, and I must say these are official requests, come to the clerk's office. We're not talking about the hundreds of phone calls that we get to the constituency offices from people wanting to know how they can become a part of this process, a part of the process I might suggest that Mr Harris promised them. I'll quote from what he called his Northern Focus Tour, back in January 1995, which he waved in the faces of many of my constituents in June 1995. It indicates, "Recognizing the special needs of people in the north, we will give northerners a direct say in changing the Ministry of Health's planning and resource allocation so that it concludes more consideration for northern priorities and conditions."

I must say, had it not been for the opposition tactic to get this show out on the road, the people in Timmins and Sudbury and Thunder Bay, and here in Ottawa, would not have been heard in their local communities. As I suggested to the presenter that day in Sudbury, there was no way that she would have been heard in the hearings that the government had suggested, up until that turning point.

As Ms Lankin has already indicated as well, we've had an overflowing crowd in every community that we have been to. These are people who have come in the hope that there may be a spot for them, people who have shown a great interest—more interest than I've ever seen in a committee in my eight years as a legislator. I have to say that we have to take another look at what we're doing here. Ms Lankin has indicated that she would like this to go back to the House leaders for their discussion. I see nothing wrong with that. We have three House leaders sitting in Toronto, and I think they should have the opportunity, and I think this committee should give them that opportunity through this motion, to take another look at the number of people who want to make presentations to this committee as we move throughout the rest of the province and throughout Ontario and give them those opportunities.

We will certainly be supporting this motion.

The Chair: One minute left, Ms Lankin.

Ms Lankin: Let me just start by saying very briefly that I would dispute claims that Mr Clement continues to make about this bill having more public input than any other bill in the previous two legislatures. That is just patently false. I can show you the kinds of discussion papers and consultations that went into drafting of legislation, the kinds of public processes that were involved, which are all part of good governing and good legislation which is completely missing in this bill, which is unprecedented in its scope and unprecedented in the speed with which it is being rammed through.

You've said to people that you're listening. How can the people in this room have any faith that that is true when the vast majority of people who have come forward

have asked for this bill to be split up and certain portions of it to be slowed down so there can be greater public input? If you're listening, then support this resolution, which does not determine the matter but simply says what this committee has heard and passes on that concern of the public to the House leaders for the House leaders to determine.

It is not our job to set the House agenda; it is the House leaders' job. It is our job to pass on recommendations from what we hear from people, and if you are truly listening, Mr Clement, you will finally support this motion, because this is what we have heard over and over again from the people of Ontario.

The Chair: We will now call for the vote. Ms Lankin has asked for a recorded vote.

Those in favour of Ms Lankin's motion?

Ayes

Lankin, Miclash.

The Chair: Those opposed?

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated, three to two. We'll recess until 1 o'clock.

The committee recessed from 1211 to 1301.

ONTARIO DENTAL ASSOCIATION

The Chair: Good afternoon. Dr Roger Howard is here representing the Ontario Dental Association. Welcome to our committee. We'll ask you to introduce all the presenters. You have a half-hour of our time. Questions, should you allow time for them, would begin with the government. The floor is yours.

Dr Roger Howard: Good afternoon, Mr Chairman. Thank you for this opportunity to meet with the committee about the Savings and Restructuring Act. I'm Roger Howard. I'm a general dentist practising here in Ottawa, and I'm also president of the Ontario Dental Association. With me today is the ODA's executive director, Mr John Gillies, and our director of professional affairs, Linda Samek.

The Ontario Dental Association is the voluntary professional organization which represents the dentists of Ontario, supports our members in the provision of exemplary oral health services and promotes the attainment of optimal health for the people of Ontario. As independent health providers, our members understand the challenges of delivering care within today's dynamic and changing environment. The changing economy is just one of many factors that must be considered in the management of our own offices as well as within Ontario's health care delivery system.

As responsible health care professionals, our members recognize that it may be necessary to implement some system-wide changes if we are to balance the delivery of quality health care services while managing related public costs. We believe we can and must accomplish the dual goals of delivering quality care and controlling costs without dismantling the existing legislative framework.

Let me assure you this is not a plea to retain the status quo. We are not resistant to change, but we are concerned that the omnibus legislation has created an atmosphere of fear, mistrust and confusion for health care professionals and the public alike.

There is a perception that the government is attempting to tear down current structures and have the minister take control of the day-to-day management of the health care system, especially our hospitals. While we do not subscribe to this theory, we recognize the need to find avenues that will enable all parties to enter into meaningful partnerships with the government. The ODA wishes to assure members of the committee that it's our intent to work with the government and other interested parties to develop responsible solutions to identified problems within the current system.

Our goal is to ensure that the legislative framework supports a health care delivery system that recognizes the needs of the public, the responsibility and accountability of individual practitioners, and leadership from the community, from health care workers and the government. As we revise the existing legislative framework, we must work to preserve key Canadian values such as providing access to care as close to home as possible, delivering quality care, maintaining individual dignity and contributing to the quality of life of individuals.

As we stated earlier, we believe that the balanced evolution of our health care system depends on a cooperative partnership with government—a partnership of providers, voluntary and regulatory organizations, our public institutions, the ministry and the public that we all serve.

As a voluntary professional organization, we are here today to discuss some of our thoughts about this bill and how it may affect Ontario dentists, other practitioners and individual Ontarians. We believe it is possible to find practical solutions to some of our concerns about the bill, solutions that will work for the government, for providers and for the public.

With this as background, we trust that you will find the following comments helpful.

The first of the three or four areas we will address relates to the areas of confidentiality and recordkeeping. Under part II of schedule F, amendments to the Public Hospitals Act, there is a provision to draw regulations regarding the ownership, custody, use, disclosure, retention and disposal of medical records.

Similarly, part IV of schedule F, amendments to the Independent Health Facilities Act, permits the minister to collect, directly or indirectly, use or disclose personal information in the administration of the Independent Health Facilities Act, the Health Insurance Act or the Health Care Accessibility Act, or for other purposes that may be prescribed.

Schedule H, the amendments to the Health Insurance Act, outlines amendments to the Health Insurance Act and also permits the minister to enter into agreements to collect, use and disclose personal information concerning insured services provided by physicians, practitioners or health facilities.

In Ontario, our health care system protects the privacy of the patient-practitioner relationship. There are specific

legislative requirements that seek to protect the welfare of children, and other limited circumstances of public protection that provide for the release of information. Our patients rely on their health care providers and our public institutions and structures to safeguard their personal privacy, yet the broad powers of information collection and disclosure scattered throughout Bill 26 provide no limitations for government respecting either the patient-practitioner relationship or the release of the personal and private information contained in the patient record.

The powers of collection and disclosure granted to both the Minister of Health and, under the Health Insurance Act, to the general manager of OHIP are too broad and vague. If they were adopted, these new sweeping policies would violate patient privacy. It is particularly disturbing to find that the powers do not appear to be limited to the delivery of insured services. Rather, there is a blanket provision which deems insured persons to have authorized the disclosure of information related to services provided by a physician, practitioner, hospital, health facility and any other prescribed person or organization.

We believe that the vague language related to data collection and disclosure may lead to the release of confidential information which could be harmful to individual patients or groups of patients. With a better understanding of the goal of such clauses, we would be able to build in needed public safeguards. The unrestricted powers appear to be both unnecessary and unreasonable. The public we serve, health care providers and our public institutions need to understand what information will be released and how the information may be used.

We are pleased to learn that the minister is working closely with the privacy commissioner and reconsidering all sections of the legislation related to the collection, use and disclosure of information to ensure that the necessary information controls are built into the legislative framework. Because of the potential for the inadvertent release of patient information, it is not practical to leave the development of protective safeguards to the regulation-making process. Meeting the concerns outlined by the privacy commissioner and others, including limitations on the collection, uses and disclosure of information in the act, would result in a significant improvement in this legislation. We certainly look forward to an opportunity to review amendments in this area.

Turning to another recordkeeping matter, we suggest that consistent recordkeeping requirements be introduced for practitioners. Recordkeeping regulations are drawn under the Regulated Health Professions Act and the related profession-specific acts; therefore, we do not believe it is necessary to draw additional recordkeeping requirements under this legislation for regulated providers. While we believe it may be redundant to set out recordkeeping requirements in the Health Insurance Act, we suggest that any parallel requirements for regulated health care providers be consistent with the profession-specific clinical and financial recordkeeping requirements. This approach will avoid confusion for practitioners and permit practitioners to take a streamlined approach to recordkeeping.

1310

The second matter we want to touch on is the change in definition under the Independent Health Facilities Act. Under the existing legislation, an independent health facility means "a health facility in which one or more members of the public receive services that are insured services and for which facility fees are charged, but does not include a health facility mentioned in section 2."

We do not understand why the phrase "insured services" has been dropped from the meaning. Without any understanding of the intent of this change, we're concerned that some of our members may inadvertently be captured under this new definition. As the majority of our members do not provide OHIP-covered services, you can understand our apprehension about this wording change. We're flagging this as a potential problem and suggest that the phrase "insured services" remain in the definition of an independent health facility.

The next matter on our list is the setting of fees for insured services at nil, at zero. The ministry has established both a fee-for-service payment system and an alternative delivery payment mechanism related to the delivery of insured health services. Under this legislation, the ministry retains the right to establish covered services and also to establish services that will not be considered to be covered for the purposes of the Health Insurance Act. We expect that the ODA will continue to be included in the consultation which leads to the establishment of either an insured or a non-insured service. But, with the consultation completed, we would not support the establishment of zero-rated insured services.

Under the OHIP fee-for-delivery system, our members continue to subsidize the delivery of insured services to the public. We accept that the OHIP schedule of benefits does not reflect the true cost of providing services. We cannot, however, accept that government would mandate practitioners to provide services for free.

Our members believe in charity, and through our component societies many dentists participate in local programs such as Dentistry With a Heart where individual dentist offer their services free of charge. But this is a voluntary charitable program. In our view, charity should continue to be an individual choice.

These decisions are taken voluntarily by individual dentists out of their sense of professional responsibility. As with all those who provide public services, these are private acts of charity that are part of any civilized society. In the past, legislators decided that society should not have to rely solely on such private acts of charity to meet basic needs such as health care. We should not consider returning to such an era.

If the ministry is intent on not paying for specified services, those services can be delisted. Therefore, we ask that subsection 17.1(4) of the Health Insurance Act be deleted to ensure that practitioners are not required to reduce fees for OHIP-covered services to nil.

A prime concern for the ODA relates to the role and powers granted to the general manager of OHIP. With the increased role and powers granted to the general manager, protective checks and balances are lost. Under Bill 26, the physician or practitioner review committees need not receive referrals from the general manager for

investigation. Instead, the physician or practitioner must request that the appropriate committee review the decision of the general manager. Further, for the practitioner to have the decision reviewed by the committee, an application fee must be paid. This fee merely serves as a roadblock in the process of achieving a full investigation and a hearing related to the matter.

It's particularly disturbing to learn that the findings of the appeal to the review committee would not be supported with the review committee's reasons for the decision. The written reasons for the decision will only be made available to the persons affected upon request. Finally, the physician or practitioner who is required to reimburse the plan will be required to pay an additional amount for the cost of the review.

We are concerned that the general manager is granted excessive powers that would be better placed in the hands of a review committee charged to investigate the matter and make appropriate findings. We recognize that an OHIP profile of a practitioner or a patient inquiry may cause the general manager to believe that there are billing irregularities. However, there is no mechanism outlining the manner in which the general manager should make a final decision about these matters. In fact, we are concerned that the general manager would be asked to make decisions about whether services were medically or therapeutically necessary and provided in accordance with accepted professional standards. It is one matter for the general manager to suspect that there may be a problem, based on information such as the volume of services provided; it's another to expect that a judgement could be made on superficial information. Is the general manager expected to make a patient diagnosis to determine medical necessity?

A clearly defined process, including a formal review by an appropriate committee, is required to make decisions which will have an impact upon the reputation and livelihood of individual practitioners. Unfortunately, the cost of achieving this due process under Bill 26 serves as a deterrent to the practitioner who wishes to simply resolve the matter. In our society there is a generally accepted custom to prove that there is a finding of guilt. We create a slippery slope for justice when a single bureaucrat is granted the authority to identify a potential billing problem and simultaneously is granted the power and responsibility to make decisions based on that assumption of guilt.

Despite our concerns about the role and authority outlined for the general manager with respect to the management of the system, we agree that the review process must be seen to be more efficient. The establishment of multiple review panels may assist in streamlining the decision-making process, but we believe more can be done to fix today's problems by involving the professions in the solution.

Therefore, we propose that an ad hoc committee of professions that receive payment from OHIP be formed to develop solutions that will balance the need for an efficient and effective decision-making mechanism intended to eliminate abuse and, as necessary, seek reimbursement from practitioners while ensuring a fair process is available to those suspected of utilizing the

system inappropriately. The ODA would volunteer to lead such a process if the minister would delay proclamation of this section for a six-month period within which the parties would be required to arrive at an alternate solution to this matter. We think this is a workable solution that leaves the onus of designing an acceptable review process in the hands of those who must live with the result. In the end, the government retains the authority to implement an alternate process, but we believe that providers have the incentive to develop a fair review mechanism: fair for providers, fair for patients and fair for government.

Before closing, we want to turn briefly to the importance of strategic planning. Because we believe that tough times require the best in strategic planning, we want to touch on our concerns about the planning disincentives built into this legislation.

The authorities granted to the minister to alter funding terms, to set fees at nil and to revise agreed-upon human resource plans are just a few of the examples of system-wide planning disincentives. Now more than ever we need to explore options that will reward sound fiscal and professional planning to make the most of our resources. We need to develop systems that encourage all parties to honour commitments that were made in good faith. We need to develop a framework that ensures the public they can rely on the agreements carved out by regulated professional providers and the government in the interests of society. We cannot manage this complex health care delivery system in a reactionary mode.

There is much more that must be said about Bill 26, and our association will be providing the committee with a detailed brief in the next few days. We believe these hearings have provided an opportunity to explore areas that can be improved upon without detracting from necessary government controls. We are pleased that there was an agreement to engage in this important consultative process.

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As we conclude our remarks, I will quickly summarize some areas of the bill that we have asked the committee to consider: first, the need to build in appropriate protections for the collection, use and disclosure of confidential patient information; second, the need to include the phrase "insured services" in the definition of "independent health facility"; third, the inappropriateness of establishing zero-rated fees for covered health services; fourth, the opportunity to establish a multidisciplinary committee to consider alternatives to the proposed sections of the bill related to the powers of the general manager of OHIP and the role of the physician or practitioner review committees.

I don't need to tell all the members of the committee that this is a very complex bill. You have a great deal of work ahead of you. We trust that our comments will be helpful in your deliberations. If there is still time, we would certainly be pleased to answer any questions.

The Chair: Okay, thank you. We've got about three minutes per party, beginning with the government.

Mrs Ecker: Thank you very much, Dr Howard and Mr Gillies and Ms Samek, for taking the time to come to Ottawa and provide some excellent suggestions on the legislation.

Just a quick point on removing the words "insured services" out of the Independent Health Facilities Act. I can appreciate the point you're making about the impact on the dental profession of that, but my understanding of the purpose of that is that the difficulty when the legislation was originally put together was that it limited itself to insured services, and the quality assurance provisions within that legislation were therefore limited to just those kinds of clinics and facilities, which at the time was a legitimate judgement, I understand, because that's where most of the services were.

We now have a whole bunch of clinics and facilities that are offering a lot of kinds of services, from cosmetics to other things. There have actually been deaths, at least one death that I'm aware of. The intent was to try to take those quality provisions and extend them to some of these other kinds of clinics where they need this. So that was one thing, as I understand. You may wish to elaborate on that.

The other quick question I wanted to ask was that the College of Physicians and Surgeons, I understand, has brought forward suggestions for streamlining the medical review process to go after some of the misuse in the system. You're suggesting here a review process from the professions. Are you suggesting that would be in addition to, or are you familiar with what's perhaps happening there? It's certainly a unique suggestion that may well be worth looking at.

Dr Howard: I'm not familiar with what the physicians are proposing. We would be pleased to help lead any process that would find a solution that would meet the needs of the government as well as meeting the needs of the profession and the public.

Mr John Gillies: I think our concern principally, on the first part of Mrs Ecker's question, is that certainly the government has a responsibility to deal effectively with the services for which they are responsible as the payors. The way that we read the bill, that could be extended significantly to virtually replace the public licensing authorities or the regulatory bodies that are in the field. After going through this whole concept of the health professions legislation review that was initiated in 1982 that we've all been working on over this long period of time, it seems silly for the government now to turn around and just displace that whole exercise that's taken place over that period.

Mr Mclash: Mr Chair, you'll remember that at noon I read into the record a quote during the debate on a resolution that we had put forward to us, and that's to extend the hearings because we're hearing from such groups as this. I referred the document that Mike Harris put out at that time saying that he was going to consult with the people across the province of Ontario in terms of any changes to the health care system.

You represent a good number of health care professionals in this province. The question I would ask is, as I've asked many times to a number of deputants before the committee, were you consulted on any part of the drafting of Bill 26 before it was presented?

Dr Howard: We were not consulted before the legislation was drafted. We certainly welcome any opportunity that we have to meet with government and

discuss our concerns. Any opportunity for dialogue between the professions and the government we think is useful and helpful. We believe the ODA has a track record of working with government to find solutions that meet the needs of government, the professions and the public.

Mr Miclash: Do you know of any other groups that were consulted in the drafting of this bill?

Dr Howard: I wouldn't be able to comment on other groups.

Mr Patten: I likewise would like to congratulate you on your paper: very thoughtful and a very nice demur by which you present this. But there are some very serious points that you've identified, two of which in particular I'd like to know, if not changed in the proposed legislation—the inclusion, for example, of “insured services” and the establishment of zero-rated fees where you're obliged to provide those services without any compensation. If those are not done, what's the impact on your profession?

Dr Howard: I'm sorry. Could you repeat the last part?

Mr Patten: The impact on your profession potentially, if you could do a best-case/worst-case scenario. If no amendments are made to the legislation as it is now, if it does not acknowledge the insured services definition, for example, what could potentially happen?

Dr Howard: I think as you have identified, practitioners would be required to provide services at no fee, and we don't feel that's appropriate. If the government does not wish to pay for a particular service, that service should be delisted. If they wish to pay for that service, it should be part of the covered services.

Ms Lankin: I too appreciate the constructive tone of your presentation. I think there are some very good suggestions there.

A comment before I ask my question. Throughout the brief you've made some references to the concern you have about the need to develop protective safeguards in the legislation and not leave it to simply the regulation-making process, which is much more behind closed doors and not open necessarily to the kind of public input and scrutiny these public hearings are providing for the legislation itself. You've said that with respect to the privacy commissioner's concerns, with respect to the general manager of OHIP's concerns, but you have suggested perhaps an alternative that allows for a six-month process before this piece of the legislation is proclaimed.

I just caution you that what you end up with at the end of the day then is perhaps a voluntary agreement, but with a piece of legislation that still provides all the powers to the general manager of OHIP to make those determinations about medically and therapeutically necessary services. The problem you have is that while you might have a very good relationship with the current Minister of Health, at any point in time that voluntary agreement can be abandoned and you rely on what is in the legislation. So I think our opportunity to get it right is now, by building these things into the legislation. That's just a comment.

I want to come back to the independent health facilities question, because Ms Ecker has today and on other

occasions said the intent is to extend the quality control provisions to a whole range of other health care settings, and that could well include your profession, chiropractors and many more. It also would extend the right to revoke licences on 24 hours' notice, to hand out licences without tender, to open up for-profit, American-owned as opposed to the system that's there now.

You're regulated by a college. What are the quality controls there? Should we be concerned that you don't have any quality assurance, and do we need this legislation, as Ms Ecker said, to extend that?

Dr Howard: A comment to your comment. I think, as you know, we strive to maintain good relationships with any Minister of Health.

Ms Lankin: That you do.

Dr Howard: On the second aspect of that, the concern on the regulatory authority, we do have a mandated quality assurance program. Every regulated profession in Ontario does so as part of the new disciplines under which we operate. So we're having some difficulty in understanding the transfer that appears to be taking place here, and quite frankly we haven't captured the rationale for it, although we certainly recognize that the concerns are great and the impact could be very ominous.

We have some degree of confidence, I think, that people will be aware of the concern and the fact that there may be other methods of dealing with this, and I think the consultative process that is taking place at these hearings hopefully will result in the necessary changes.

Ms Lankin: We hope so too.

The Chair: We appreciate your presentation with us today and thank you very much. Have a good day.
1330

CANADIAN UNION OF PUBLIC EMPLOYEES LOCAL 870

The Chair: The next group is the Canadian Union of Public Employees, Local 870, represented by Betty Sommers. Good afternoon and welcome to our committee.

Ms Betty Sommers: My name is Betty Sommers and I am the president of the Canadian Union of Public Employees, Local 870, representing approximately 450 workers at the Perley Rideau Veterans' Health Centre here in Ottawa. But I am here today also representing more than 20,000 health care workers, including nursing and support staff here in Ottawa-Carleton.

The Savings and Restructuring Act represents an enormous fraud and breach of promise perpetrated against the people of Ontario by the Harris government. It is the prelude to a revolution, not a Common Sense Revolution, but one that achieves its goals at the expense of the elderly, the poor, the disabled and all the vulnerable members of our society who seem to be heartily despised by those currently in power. Bill 26 is not about reform or even saving money; it is about slashing programs, privatizing our social support system and, on a more fundamental level, dismantling the democratic structures that give the citizens of Ontario control over the future of their province.

In regard to health care, Bill 26 gives the Minister of Health unlimited authority to enact the onerous cutbacks

announced in the government's economic statement. The elimination of funding to the hospital sector alone could result in the layoff of up to 26,000 workers—up to 2,000 in Ottawa-Carleton—and will severely restrict access to health care services. Bill 26 will profoundly damage publicly funded medicare and encourage the privatization and corporatization of health care, similar to the American style of health care. If this legislation is enacted, we will see rapid encroachment by the private sector, whose goal is to see profit from illness, disability and death.

This government, if it chose to do so, could promote genuine reform that would improve quality and access to care in an equitable and cost-effective manner. Key to this type of reform is the creation of a supportive environment for good health, which includes a strong social safety net and other public policies that ensure shelter, education, food and a safe work environment. Governing bodies of the health care system need to be democratic, accountable and representative. In addition, specific action must be taken to stop the true waste in the provision of health care, namely, the elimination of fee-for-service payments which encourage overbooking, over-prescribing and overtreatment by physicians. In addition, we need to enact genuine patent law reform that promotes lower drug prices. Controlling drug costs would free up millions of dollars for health care. Streamlining administration would save millions of health care dollars by eliminating unnecessary site-by-site duplication of services.

Finally, we must preserve and strengthen the Canada Health Act. Unfortunately, recent statements by the Minister of Finance indicate that this government sees the Canada Health Act as an impediment to their ability to privatize health services.

Cuts to the drug benefit plan: The Ontario drug benefit plan provides payment for prescription drugs to seniors and those on welfare. Should schedule G be enacted, the legislation will have dramatic impact on low-income persons and seniors. Bill 26 would put a two-tier health system in place, since a user fee for prescription drugs will be introduced. This, along with the proposed \$100 deductible for the poor, will mean large numbers of the sick will be unable to afford treatment. This is another breach of promise by the proponents of the Common Sense Revolution, who clearly stated in their election campaign that new user fees would not be introduced and that services to seniors and the disabled would remain untouched. As with other sections of Bill 26, the minister and cabinet will have power to establish and set, behind closed doors, the levels of user fees under the Ontario drug benefit plan. Cabinet will essentially act as pharmacists, making decisions over which drugs are eligible to receive reimbursement under the plan.

The interference in the medical process by the government is astounding. Medical necessity or other health criteria do not have to be considered; cost will be the criterion.

Deregulation of drug prices: Bill 26 will repeal the power of the minister to regulate the prices of drugs charged to anyone not covered under the Ontario drug benefit plan. Drug companies will be free to determine the prices for products other than those provided under

the drug benefit plan. Without regulation we can expect that the cost of drugs will increase substantially.

The government is also putting itself above the law. Not only does the legislation remove any public process for setting prices of drugs and determining issues under the Ontario drug benefit plan, but it is reversing court rulings that went against past government decisions.

Power to impose user fees: Bill 26 would provide explicit authority for cabinet to make regulations which could permit hospitals to charge user fees for any hospital-based insured services, including those already covered under OHIP. As an example of this, the government has already announced that hospitals will be able to charge daily user fees to those patients in acute care beds who are awaiting placement in chronic care facilities or nursing homes. Patients will essentially be penalized because they are forced to wait for services that are already critically underfunded and are going to be cut even further by the Harris government.

With this new legislation, the Tories are encouraging hospitals to offset their budget reductions by charging user fees, allowing them to bring in additional revenues at the expense of the patient. This is yet another example of the broken promises by the Tory government, which promised the citizens of Ontario that no new user fees would be introduced during its term of office.

Delisting of medically necessary services: To date, the Health Insurance Act has required that OHIP cover all medically necessary services. Under Bill 26, the cabinet will decide which services are insured and under what limitations and conditions. These provisions will most likely be used to limit access to services which are now provided under the Health Insurance Act. The government can decide at will which types of care are medically necessary and which are not. The potential for abuse is enormous, and certain services which are currently covered under OHIP could be delisted simply because the government decides they are too expensive.

Loss of confidentiality of medical information: Confidentiality of personal medical information becomes a thing of the past under this legislation. Bottom-line economic considerations will override the right of citizens to have their personal medical histories held in confidence. Bill 26 will allow the minister to collect, use or disclose personal medical information for various administrative purposes.

One of the key rationales for this disclosure is that it is necessary for the "effective management of the health care system." Those who are most vulnerable in our society could find themselves the victims of a campaign to deprive them of adequate and necessary levels of care, because the government deems them to be abusers of the system.

Impact of Bill 26 on hospitals: Bill 26 will give the minister virtually unlimited powers with respect to the funding and operation of public hospitals. It will allow the minister to ignore the needs and desires of the local communities, such as Ottawa-Carleton, that access hospital services and give him unlimited control over all hospital matters.

Ottawa-Carleton is facing a 38% increase in demand for health care services, which will exist as a result

of estimated growth and aging of the population by the year 2006.

We in Ottawa-Carleton should not be cutting any more acute care beds. Ottawa-Carleton has decreased its inpatient hospital utilization rate by a staggering 43% between 1989-90 and 1993-94, with a further 104 acute care beds that have been cut since that time. Ottawa-Carleton already has a significantly lower acute inpatient day rate per 1,000, at 647, than the provincial average at 694, or Klein's Alberta rate at 927, where protests over hospital cuts have resulted in a moratorium on further cuts.

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Our calculations indicate that if we adjusted the acute care bed complement of 1,874 beds in 1993-94 to reflect the estimated demographic growth to the year 2006, approximately 2,586 acute care beds would be required, which is 816 more than currently exist.

As for chronic care and long-term care, at this time there are 169 persons awaiting placement into chronic care and an astounding 1,111 persons are waiting for a bed in a long-term care facility.

Currently in the Public Hospitals Act, funding is allocated by specific criteria and regulation. The minister cannot terminate funding simply for budgetary reasons. His decisions must take into account their effect on patient care. Under Bill 26, however, the minister can decide that the availability of financial resources is the only relevant criterion when making funding decisions.

The minister also has the unlimited authority to close hospitals, force mergers between institutions or order hospitals to change or eliminate the types of services that they deliver. Since the government has made it clear that it thinks that too much money is spent on inpatient services already, it can also use this bill to compel hospitals to reduce the volume of acute care that they provide. This will result in patients being forced out of the system much too quickly, or even denied appropriate levels of care. As a result of these changes to health care, we believe that people will die unnecessarily.

Since the government has also stated that up to 38 hospitals in Ontario must be closed, the bill will provide it with the necessary mechanism to achieve this goal quickly and aggressively. No public consultation will be necessary on even a superficial basis.

Finally, Bill 26 provides tremendous levels of liability protection to the government during the restructuring processes. They cannot be sued or held accountable for virtually any actions that they take under the authority of the new legislation. The Ministry of Health will become a dictatorship and the citizens of Ontario will have no recourse or protection from the damage that will be inflicted on them by the Harris regime.

Privatization through independent health facilities: Changes to the Independent Health Facilities Act essentially eliminate tendering processes by giving the minister the authority to request proposals from specific individuals for the establishment of a private health facility. The new legislation will also eliminate the requirement that preference be given to non-profit Canadian operators.

These changes will allow the Minister of Health to handpick corporations or individuals to open up shop,

even open up franchises of health care clinics that charge patients money. In tandem with the massive cuts being proposed to health services, it seems clear that this new legislation will allow health care gaps to be filled by more private companies intent on making profit from sickness.

Interest arbitration: We strongly object to the proposal which would force arbitrators to consider ability to pay in determining their awards. Funding in the public sector is determined by financial decisions. Thus, if ability to pay were a criterion in interest arbitration, the Harris government could determine wages and benefits simply by allocating fixed or reduced amounts for employee compensation. The introduction of this kind of restriction would make the interest arbitration process a complete sham.

We believe that the most appropriate way to settle collective agreements is by allowing the parties to test their strength with the option of resorting to strike-lockout mechanisms. Legislation which forces compulsory arbitration on certain groups of employees should be repealed and these employees should be granted the right to strike. They have already been denied these rights because previous governments have deemed their work to be part of an essential service. It is, however, ludicrous for the current government to hold the same position. If the Tories can eliminate the jobs of up to 26,000 hospital workers, then surely they cannot deem their work to be essential.

Conclusion: This government's attempt to ram through Bill 26 with virtually no public consultation is a fore-shadowing of the way the business of the province will be conducted in the future. If the Tories have their way, all government will be a business, one committed to transferring as much of the public purse as they can into the hands of their friends in the private sector, regardless of the impacts on the citizens of Ontario. These impacts will be severe, and none more so than on the delivery of care, which will no longer be based on access or quality of services but on the financial considerations and the desire to privatize Ontario's medical system.

The proposes changes to hospital and health services will damage beyond repair publicly funded medicare, a system which tries to protect all Ontarians in an equitable and compassionate manner. If this legislation is enacted, there is no doubt in our minds that the people of this province will experience a rapid and tragic decline in the quality of care they currently receive.

Taken as a whole, Bill 26 represents a vicious assault on basic principles of democracy and accountability. It is a perversion of the trust placed in the government by the electorate. It illuminates the multiple deceptions and contradictions and shows the Common Sense Revolution to be nothing more than a dictatorship.

On behalf of the thousands of health care workers here in Ottawa-Carleton, we demand that the Harris regime withdraw Bill 26 in its entirety or face the democratic consequences of a betrayed electorate.

The Chair: Thank you. We've got about four minutes left for questions, beginning with the Liberals.

Mr Patten: Thank you, Ms Sommers. A number of the issues you raise have been identified by others as well,

particularly the concern about the overwhelming power grab in this bill. Given your position with CUPE, when you discuss among yourselves, what fears do you have related to jobs? How many jobs do you see this affecting in terms of lost jobs, in terms of perhaps part-time jobs or this sort of thing?

Ms Sommers: In analysing the figures, we figure at least 2,000 jobs lost or reduced from full-time to part-time; at least 2,000 jobs here in Ottawa-Carleton.

Mr Patten: That's a lot of jobs.

The provision you identified of ability to pay is a crucial element, in your view and in many others' as well. We have to adjust arrangements for a perceived expensive system, and if not contain costs, find costs. This government's committed to that. What contribution can the union make to the frugalization or the efficiencies of a system that are not continuing to rise in cost?

Ms Sommers: That's a difficult question to answer, but I feel there are many ways that could be addressed. There is wastage in the system. In our workplaces we see it. There's duplication of administration services, there's waste of food, there's waste of everything, and that all costs money. Our members feel very strongly that if issues even as small as that were looked at, thousands and maybe even millions of dollars would be saved in the systems.

Ms Lankin: Thank you very much. I appreciate your presentation. I have questions in two areas. I'm going to start off with the issues you raise around interest arbitration. I'm glad you've raised them. I believe the government genuinely doesn't understand, because it has said it thinks it's reasonable that ability to pay should be considered, that it's a limited purse. They don't understand that what arbitrators have come to say very strongly in the past is that ability to pay is simply willingness to pay in terms of the decisions made about budgets, about revenues, and workers have no control over that. I've urged them to read the Johnston commission report coming out of the CUPE hospital strike so many years ago that set out a lot of this.

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But I want to deal with one particular group of employees that will be affected. This affects police and fire, and under the Hospital Labour Disputes Arbitration Act nursing home employees are covered and for-profit nursing home situations will be covered. Here we'll have a situation where for-profit employers, businesses, will get to determine what on their bottom line goes to the profit, what's left over, go over and make a pitch to an arbitrator that that's what they have the ability to pay and those workers' wages will be affected by that decision. Am I correct in my understanding of the application?

Ms Sommers: Yes.

Ms Lankin: Your union represents some of those. Can you talk about where they're at now on the wage scale and what you think this means for that group of employees?

Ms Sommers: Especially for workers in the nursing home sector, they are already grossly underpaid, and the majority of those workers are women. If wages and benefits were to be reduced even further, they would not be able to work in those jobs because it wouldn't even be

feasible to be there. Then where would they be? On the welfare lines and wherever. That would be an added burden to the province.

Also, the concerns I hear from these nursing home workers is that they're grossly underpaid and the quality of care we're delivering is already at risk because there is reduced staff as it is. These owners are running a business for profit and if they can get three people to do the work of six people, they'll try. Who's at risk more than the patients in these nursing homes?

Ms Lankin: My second question is around some of the concerns you raised about services being unilaterally delisted. The possibility is there for that in the legislation. I read into the record the other day a letter from a doctor to a senior cabinet minister in this government in which he reiterated a discussion they had that set out an intention on the part of the government to develop a list of core services. We've heard this elsewhere.

Yesterday we heard from a bioethicist who said this necessarily means that those things that are not covered will be paid for in the private market. There are some people in this province who believe that's the appropriate way to go, that we can't continue to pay for everything. We've heard that, but that's not a debate we've ever had. It fundamentally changes the values of our health care system, and as Canadians in Canadian society, the values in our society are very intricately connected to the values of our health care system.

Have you been part of any debate? Do you think the government's campaign set out their intention in this direction? Is that a debate we need to have before this government proceeds with these kinds of powers?

Ms Sommers: Very clearly, there needs to be a good long debate on that. And no, to my knowledge, no one from the labour movement has had an opportunity for that kind of debate.

Mr E.J. Douglas Rollins (Quinte): Betty, thanks for coming to this forum of debate with the government, to the hearing. I think it does give the opportunity for dialogue. I don't always agree with the things you have, and of course we don't always have to agree, but there is an end result we need to look at.

One thing you've expressed was that deregulating drug prices would definitely cause prices to go up. Most people, particularly most people in the free world, agree that competition has a tendency to put prices down, and as soon as you deregulate that and allow these big companies to compete for the market, they're not going to sell drugs if they're priced too high. I think most people do have the ability to find out who's selling the cheaper drugs.

You also seem to think our health budget is being cut. I think it's been restated on many occasions by our minister that the dollars earmarked in that envelope for our entire health budget are going to stay the same. It may be adjusted from time to time, because we do know there have been some deficiencies and inefficiencies in the system.

We have closed some 6,500 beds in the province of Ontario in the last two or three years, but we have not closed one administration. Common sense tells you that when you remove that number of beds from the system,

somewhere along the line some of those piles of bricks should have closed doors on them; otherwise we're heating floor upon floor of hospitals that have not got anybody in them. They're just there; they're not running at capacity. It's more efficient, more commonsense to close one or two or three of those hospitals, put those facilities together and make them more efficient. That's one of the things this government has been trying to do.

You stated that we said we were closing 38 hospitals.

Ms Sommers: I said up to 38.

Mr Rollins: That's a little misleading: up to 38 hospitals. We will probably look at closing any hospital where there can be some amalgamation and some dollar saving to keep allowing the public to have the good service they have. You've stated here that you've got 169 people waiting on a list, you've got 1,011. Is it working now? I would say it isn't. Is the system working now?

Ms Sommers: The system isn't working properly, but the answer is not to close hospitals. The answer is to look at who is in those beds. As you said, X beds have been removed from the system. Why have those beds been removed from the system? Because there has been no funding dollars for those beds. It's not as if there are not people waiting to go into these beds.

Mr Rollins: In all fairness, we've changed the system around and we have to give the hospitals some credit. These hospitals have put a lot more patients through in a lot shorter time and have done a lot of day surgery that's put people back out into the system, to still allow us to continually support other payments.

There's a perception that this government's in the position that we're going to null and void all health care. That is not the intent. We want a better bang for our buck, and we're darned well going to try to push every department and every facility of it to try to get it.

You also mentioned the arbitration. Over the last four or five years, as anybody who reads the paper well knows, arbitration has never taken into consideration the ability to support of the people paying the bill. All they're looking at is one thing and one thing only, entirely on the one side of it. Those arbitrators are going to be asked by this government to take a good, firm stand in looking at the ability to pay of the people who provide the tax dollars. You and I and all the rest of us are the taxpayers. That's who we have to look after. We can't afford to raise more taxes. It just doesn't work that way any more.

The Chair: Thank you for your presentation. We appreciate your involvement in our process.

CHARLES SHAVER

The Chair: The next presenter is Dr Charles Shaver. Good afternoon, and welcome.

Dr Charles Shaver: Thank you. First of all, I'd like to give everybody in this room a bit of background, because if you know where I'm coming from, you'll understand why I'm here.

I was born in Montreal. My father was a neurosurgeon, trained under Dr Penfield, was forced to go to the United States for further training and could never return to Canada—lack of jobs. I grew up in the Midwest, went to

Princeton on a full scholarship, graduated in biochemistry in 1966, to Johns Hopkins in 1970, and returned to Canada that year. Probably because of the 24 years I spent in the United States, I've been very attuned to issues such as freedom and justice and equality, and that's why I'm here today.

I spoke before the Peterson government about 10 years ago in Toronto when Bill 94 was being discussed, and at that time I was looking for something that would make the public concerned about progressive erosion of freedom of physicians. At that time I predicted that there might well be a loss of confidentiality of patient records. I summarized it as: An employer is always entitled to see his employee's work, and our charts are our work, so the more we become employees of the state and the less autonomy we have, the greater the risk is that the government can at its will look at private patient records.

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I'd like to just quickly go over my presentation here, which many of you have. I might let you know that this was published today in the Hamilton Spectator and it went on the wire services of Southam, so it may appear in some of the other regional newspapers.

As you know, this bill is scheduled to pass final reading on January 29, and in it the Ministry of Health will assume unprecedented powers and will be able to dictate when, how and if physicians can practise. Existing agreements with the Ontario Medical Association will be cancelled and the subsidy of malpractice insurance will cease. These issues have been covered elsewhere, and I will not deal with them here.

The minister alone will determine which areas are overserved and will not issue new billing numbers to family physicians contemplating setting up practice in any of these areas. I understand there are about 12 different counties that have been designated. Seemingly ignored are situations in which a spouse can only obtain employment in a large city or perhaps in which children require special schooling.

In the Ottawa Citizen last Saturday, there was a large letter from an older physician who had practised in rural areas who is now teaching at the University of Ottawa, and he was extolling the virtues of rural practice. As I read the letter, it occurred to me that he could never duplicate this today, that he would be banned from returning to a large city to impart his knowledge to the new residents. I think this has been overlooked. A billing number is a one-way ticket to an outlying area.

The legislation also states that a specialist affiliated with a hospital has to have privileges in order to retain his billing number. Already many dermatologists, psychiatrists and radiologists practise entirely outside of hospitals. Would they then lose their billing numbers? What would happen to a specialist now at a hospital targeted for closure? Would that specialist be able to continue his office practice while looking for a new hospital appointment? If he were not able to find a hospital in this city, would he be able to locate to another city in Ontario? He probably would not be able to locate to another Canadian province, with the possible exceptions of Saskatchewan and Newfoundland, because of restrictions on billing numbers and licences, and it would

probably be easier for him to simply go to the United States.

An older internist such as myself might eventually want to give up some of his active hospital privileges so as not to be required to work nights and weekends in the emergency department. It's unclear to me from the legislation whether he'll be allowed to maintain a pure office practice during his last few years before full retirement. So it's not clear to me whether "hospital affiliation" means active or simply consulting staff.

Also, the minister would possess the authority to determine retroactively which consultations and other services in his opinion were medically and therapeutically unnecessary, but these might be based more on fiscal than on medical considerations. Moreover, the indications for many surgical procedures, medications and diagnostic tests change rapidly, and a consensus at a given point in time is difficult to achieve even among experienced clinicians. Let me give you a few examples, just in my brief professional career.

Not too many years ago, people with diverticulosis were placed on low-fibre diets. Now they're placed on high-fibre diets.

When I was training in cardiology in Toronto, Dr Donald Beanlands, who is now head of cardiology at the Heart Institute, told me and all of the other residents that a clot had nothing to do with a heart attack initially, that the clot was a secondary event. It was only a few years later that people went back to the old thinking and discovered that the clot was important, and they developed thrombolytic therapy, the use of blood thinners to treat acute heart attacks.

As far as people who were on the dialysis list awaiting a kidney transplant, in the early 1970s we were told not to transfuse these people because we would expose them to foreign antigens. Later on the concept of blocking antibodies developed and we were encouraged to transfuse patients. I understand in the past five years, after reanalysis of the statistics, these people actually did not do better with transfusion and of course they were exposed to HIV and hepatitis C. So now we've gone one and a half cycles around the clock.

If you were a bureaucrat in Toronto or in Kingston, determining whether a transfusion was necessary in a dialysis patient, what criteria would you use? The point of my examples is to show that it is absurd, that no person can indicate exactly what is or is not medically indicated.

According to the new legislation, physicians would be required to the Ministry of Health for services which were deemed "medically unnecessary." Some physicians might respond by seeking prior approval, which would of course result in a delay in obtaining services. Others would perceive that their income was now tied directly to curtailing services and would refer only patients with what appeared to be serious illnesses. Utilization would fall, but at the expense of unmet patient needs.

Throughout all of this the provincial government is sending, both to doctors and patients, a very mixed message. It advises patients to practise preventive medicine, and yet, how can patients practise preventive medicine and how can they arrange to have a stress ECG,

a mammogram, a Pap smear, a colonoscopy or even a serum cholesterol determination at an earlier age or more frequently than the government deems to be "medically necessary"? Most they travel to a private clinic in the United States?

Don't forget also that at the same time that the government is eliminating the reimbursement of malpractice insurance, they're also putting patients and physicians at greater risk by closing hospitals, closing emergency departments, so that many patients who a few years ago would have been admitted for observation with suspicious chest pains are now being sent home.

A very interesting thing which I hit upon—and I don't think anyone has discussed this before your committee—is the whole issue of the Canada Health Act as it relates to this. Some of you may realize that for the past 10 years I tried to persuade the Quebec government to comply with the Canada Health Act. It appeared to me that they were violating the Canada Health Act by not providing the full rate of reimbursement to patients when they were treated outside of Quebec.

A number of Quebec patients have been for years coming to Ottawa and seeking out consultations and tests which they perceive to be speedier or of a superior quality. They would pay out of their own pocket, knowing that they would be partially reimbursed. A whole succession of federal Health ministers, including the Honourable Perrin Beatty, has not intervened. I mention in my brief Perrin Beatty for one reason: that Mr Wilson used to work for Mr Beatty; so at that time, in an earlier lifetime, he could have had the power to intervene and tell Quebec that it was violating the Canada Health Act, and for obvious reasons he chose to keep a low profile.

I felt that maybe we should just turn the whole thing around and say that a precedent now appears to have been set, and to be consistent, the federal government should now permit Ontario patients to pay for services when they are deemed "medically unnecessary." I can appreciate that the government might not have the money to pay for a serum cholesterol every two or three months, but certain patients may wish to have this done. Why not allow the Minister of Health to pay for one annual cholesterol and, if the patient wants to have it done more often, he pays out of his own pocket?

They may not be able to afford to do a stress ECG on younger patients. If they want to set an arbitrary cutoff—and in the act they do indicate they will have that power—then fine, we will only do a stress ECG at public expense in somebody age 45 or older. But if you're 35 with a bad family history, why should you not have the right to pay out of your own pocket to have a stress ECG?

In the present system, the only way to do this is to find an insurance company, apply for insurance, and they may then require you to have a stress ECG and then it becomes a third-party payment, which is acceptable. This is ridiculous. A patient should be able to pay directly for some service that he himself wants to have.

If the federal and provincial governments do not agree with me and still feel that either the test is fully covered by OHIP or the doctor will have to pay for it or the test isn't done, then this raises the whole issue of account-

ability. What responsibility do federal and provincial Health ministers now bear for a diagnosis which is missed at an earlier, possibly more treatable stage?

Now we will get into the issue of inspectors. Bill 26 does provide for the appointment of a new class of inspectors with expanded powers. Physicians must provide all information on private patient medical records and the inspectors may remove, copy and disclose any information at their discretion. What hasn't been emphasized here, I believe, is that patients also have to cooperate, and I quote: "Every person who receives insured services shall cooperate fully with an inspector who is carrying out an inspection under the act." I'm not sure if in your earlier meetings it's been mentioned that the fine for noncompliance is \$5,000.

Who will be these inspectors? I've talked to several doctors in Ottawa who used to work in Quebec, where they've had this process for a number of years, and in Quebec these tend to be retired Quebec provincial police officers, hardly the most tactful of inspectors. How will these inspectors be trained? What investment is the government prepared to make in their ongoing education and in others making the decisions of what is "medically necessary"?

Moreover, what possible psychological trauma might occur if an inspector, having no formal psychiatric training or possibly not even an MD degree, were to interview a patient who had received psychiatric services or who had undergone a therapeutic abortion or even a number of D and Cs for recurrent miscarriages? I could foresee that an interview done over the telephone in a few minutes could cause damage that would take months to repair by a professional.

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Traditionally, the doctor-patient relationship has been based on free and open communication. In future, patients with sexually transmitted diseases, alcohol or drug problems might well forgo care for fear that their records would be scrutinized by one of the government inspectors. To what possible misuse might this information be put if it concerned a political opponent of the government in power?

Many charts contain documents requested and paid for by third parties such as insurance companies, employers and other government departments. It's unclear to me from the legislation whether these are also to be examined by the inspectors. Also, what rights do patients have over notes in older charts, written at a time when the new powers of the Minister of Health were not anticipated? Can you say that the inspector is only entitled to look at the last three pages of the chart, or can he look at the entire chart? That's unclear to me.

Amendments to the legislation which merely delete reference to the expanded powers of the new inspectors do not totally solve the problem of maintaining patient chart confidentiality. This is a very key point, very important. Don't forget it. I am not happy if you simply do window dressing and simply eliminate reference to the inspectors or indicate, "We will collect the information, but be very careful it doesn't get into the wrong hands."

Don't forget, physicians spend 10 to 12 years in training. They train for more years than almost anyone

else in society, probably. At the end of the process, they have only one paymaster. Unlike a teacher, they cannot apply to work at another school board or tutor in their own home. If they are to work in Ontario and pay their mortgage and feed their families, they have only one paymaster. They will be very reluctant to jeopardize their cash flow.

Private practice has been outlawed by the Canada Health Act and Bill 94, the Health Care Accessibility Act. Under the new legislation, Bill 26, the Minister of Health will have the power to expropriate a medical practice without any of the protections normally accorded to a small business. A specialist can have his hospital privileges and billing number revoked without any due process of appeal.

As state employees, physicians, like all other civil servants, will be reluctant to criticize their one and only paymaster, and they will lose what residual freedom they once had to act as independent advocates of their patients. Thus, without even specifying the power of the inspectors, the ability of the government to obtain access to these medical records will be absolute and unchecked as long as physicians can be intimidated by total loss of their billing number and hence their livelihood.

I'd like to raise a point at this juncture which has not been raised to your committee. We've been concerned about the power of the government over physicians. No one has discussed the power of chief executive officers of hospitals. This is a very important point. If I am reading electrocardiograms at my hospital, in order to lose the right to read electrocardiograms, someone has to prove that I am negligent; if somebody is reading X-rays, someone has to prove that he is negligent or incompetent to remove his privileges. Under the new legislation, there will be no such safety check whatsoever. If the chief executive officer of the hospital says, "I don't like the colour of tie you're wearing; you're out," there's no appeal.

I know for a fact that certain hospitals already are using this power to intimidate physicians to ask for so-called voluntary contributions to help balance their budgets. Some also may be asked to charge reduced amounts for providing care to inpatients so as to reduce the amount coming out of the global budget that normally would be paid to physicians. I could foresee a time when physicians who read electrocardiograms, let's say, will be told that if they did not accept an even lower rate, there are a number of unemployed physicians from newly closed hospitals who are prepared to undercut them and read the electrocardiograms at a cheaper price. This is much what happens in the United States now at the HMOs, and I don't think we want this in Canada.

The other thing is that up until now physicians have been the only group within hospitals who have had the knowledge of what goes on in the hospitals, and the ability to act as independent advocates for the public as to the efficient running of hospitals and to act as advocates for the nurses and other hospital employees. Under this legislation, if a physician can lose his hospital privileges with no appeal, then physicians will be muzzled, like all other hospital employees, and there will be no one to speak out on behalf of the public or on

behalf of the other hospital employees. This is a very key concept and I think it should be stressed.

In summary, I was struck by this legislation. I'm not stupid, but I had great difficulty reading this in either official language. I did not have access to all of the other documents necessary to interpret it. I doubt if a tenth of 1% of doctors would have taken the time to obtain the documents, which I did, and go through them a number of times. There were a number of things that just struck me as very unfair, and very malicious, in fact. For example, let me just quote a few things.

If you have a copy of the bill, this is from schedule H on page 100, section 27.1. Let me read this:

"Every physician, practitioner and health facility who provides insured services shall make such contribution to the plan"—we don't call it "clawback now," we call it "contribution"; we're already at the moment tithing to Mr Harris, but this is called a contribution—"as may be prescribed relating to the amount of fees payable to him, her or it under the plan during such prior period as may be prescribed."

What does that mean? As an internist I normally receive, before clawback, about \$105 for a consultation. If the government were short of cash, could it say, "Well, we think a consultation is worth \$70 and we think you've been overpaid all these years so we're going to go back to fiscal year 1990-91, 1991-92 etc, and ask you to pay back \$35 for every consultation you saw during the past four or five years"? Under this legislation, they would have that power. I would ask anyone in this room whether he thinks this is fair treatment of physicians. Are we going to be treated as second-class citizens? You may wonder why so many physicians are thinking of leaving the country now.

Another one. I know of a number of doctors who don't always get their exams the first time around. It's very difficult now to start off in family practice and then decide to specialize in anaesthesia or internal medicine. A number of barriers have been erected. It's very difficult to get into a residency training program. But this legislation adds yet another hurdle. Listen to this. This is on page 104, subsection 29.4(4):

"An eligible physician ceases to be an eligible physician"—"eligible" means he can have a billing number—"if he or she changes the nature of his or her practice from that of a family practitioner to that of a specialist."

Why do we have to have yet another barrier? Does everybody have to know at age 18 exactly what he's going to do with his life? Is no one allowed to change his mind and go a different direction? This is totally unacceptable.

Now here's one that particularly bothered me, probably because of the 24 years I lived in the United States. This is on page 112, schedule H, subsection (1.2):

"A regulation may create different classes of persons, facilities, accounts or payments and may establish different entitlements," etc.

Listen again: "A regulation may create different classes of persons...." Does that mean based on race, religion, sexual orientation, HIV positivity? What? Age? It's not spelled out. I was taught that if something is not spelled

out, I'm not content to hear that they will never abuse their power.

I find it very scary to think that this can go through as written, and I would remind everybody in this room, this whole omnibus bill, lengthy as it is, is only a skeleton, only a framework. The true flesh will be applied to the skeleton in the form of regulations, which do not have to go before Parliament. They can go only before the caucus. We are told, "Never sign a blank Visa slip, never give your Visa number out over the phone." Are we prepared, as citizens of Ontario, to hand over our charter freedoms to this government? The government did not get a mandate to do that.

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I brought with me here just a few pages of the Charter of Rights which I thought might be relevant, such things as mobility rights, every citizen of Canada, every person has the right "to move and take up residence in any province; and...to pursue the gaining of a livelihood in any province." It seems to me that's being violated.

"Everyone has the right to life, liberty...principles of fundamental justice." Are principles of fundamental justice adhered to by this legislation?

Number 11: "Any person charged with an offence" is "to be presumed innocent until proven guilty." In this legislation, nothing has to be indicated. An inspector can enter your office, not because of aberrant billing patterns but for reasons of his own; the government does not have to specify these reasons. It doesn't seem to me as if you're presumed innocent till proven guilty. Also he's "not to be found guilty on account of any act or omission."

Equality rights, number 15: "Every individual is equal before and under the law." I've heard some people say to me: "Well, after all, you doctors are making so much money. It doesn't matter." I'm afraid it really bothers me when someone says, "Well, we're not going to discriminate against you because of your race or religion, but we are because of your occupation or your perceived income."

Does the government now have the right to tell a doctor that because his income is a certain amount, it can tell him where he can live, that it can come into his office and seize his records, that it can go back in time and tell him that his services were worth much less than he's already been paid for? It seems to me that we have a two-tiered systems of rights for physicians and one system for everybody else.

I'd be happy to entertain any questions.

The Chair: There isn't a practical time left for questions. The last time we did this one-minute-per-party thing, we didn't get any answers. So you've got about three minutes left, doctor, if you want to continue on with some more comments of yours.

Ms Lankin: Oh, Chair.

The Chair: The practical one-minute-per-party thing does not work.

Dr Shaver: One thing I would like to tell you is that I have been surprised in this debate by how the press has come on side. I have talked to a number of people. I have faxed articles to people like Bob Sheppard from the Globe and Mail, Thomas Walkom from the Toronto Star,

and people who have traditionally been our enemies seem to perceive the injustice in this legislation.

But that didn't seem to be enough to derail the legislation, so early last week I took it upon myself to write some of the people on the other side of the border. Actually, two days ago I did a 15-minute interview for the New York Times. They're very interested in this and they're going to have an article out in the next few days you might be interested in seeing. This is a letter I sent to Peter Jennings at ABC in New York:

"Personal freedom, fairness and choice, always valued by Americans, are now being denied to residents of Ontario. Americans may be shocked to discover that physicians and other individuals in the democratic country of Canada have been denied their right to appeal arbitrary decisions by ministers of the Ontario provincial government.

"The Canadian medicare system, with a single paymaster, has been viewed by many Americans as a desirable model. They might now be surprised to discover that its natural evolution results in rationing of services and an elimination of freedoms and rights of both patients and physicians. Many Canadian physicians and nurses will likely emigrate to the United States in the next few years. Americans may wish to know what factors motivated their moves."

This has also been sent to CNN and to WBBM in Chicago and a few other people. I think it might provide a more objective viewpoint of what's going on in our country.

Really, I could never understand when I was growing up and going to school in the United States how a dictatorship could come to power. I'm not going to be perceived as a scaremonger here, but when I see what is happening here, it really bothers me. Again, I don't want to appear to be inflammatory, but if you think about what I've said over the past half-hour, a murderer or a rapist, such as Paul Bernardo, has greater rights of appeal than do the physicians of Ontario. That's a deplorable situation.

The Chair: Thank you, doctor.

Ms Lankin: Mr Chair, I'd like to raise a point of order with me, if I may. Let me preface it by saying that I appreciate that you have done a very, very good job in chairing as we've gone through these hearings, but both my colleague and I, in looking at the time, believe that in fact there were six minutes left at the point at which you said that there were only three, and that's a problem. I didn't object at the time because I wanted to continue to hear Dr Shaver. He had more to add and that was fine.

But secondly, may I indicate to you that the purpose of the time left over for the parties is to be used as the three parties see fit, which may include questions, often does, but sometimes it's comment on the presenter's presentation, and that you as Chair do not have a right to unilaterally change that process and to deny us that opportunity. You haven't done it before. You've been terrific in the way you've chaired. I just would ask you to take that under consideration and please not to repeat what I think was an error in the procedures.

Mr Miclash: If I may just make a comment on that as well, Mr Chair. According to my watch it was 24 minutes

after the hour, and I believe the next presenters weren't on my schedule until 2:30. At the present time it's about 27 minutes after, and I too felt that we had about two minutes per party. I fully agree with Ms Lankin that even if we didn't want to ask a question but make a comment, I think that time was ours to be split three ways, as you've done in the past.

The Chair: Not that I have to explain, I don't think, what I did, but I think you do have to allow me some latitude to manage the time. We got into an argument this morning with one-minute questions with Mr Chiarelli. I chose not to do that this afternoon. One minute is not a practical time for questions. So I think the doctor used the time more effectively.

Ms Lankin: Mr Chair—

The Chair: I don't want to get into an argument about this.

Ms Lankin: I don't want to get into an argument either. I would just suggest to you that if there are three minutes left and you think it's not practicable for questions, I could understand that, but I should have the right as a member to indicate whether or not I wish to use that one minute for a comment on the presentation that comes before us. That is entirely acceptable and is tradition under the rules. I do give you a lot of flexibility and I think you've done a good job. I've said that. I would just ask you to think about the decision that you have just made in this last presentation and please to attempt not to repeat that.

CANADIAN DRUG MANUFACTURERS ASSOCIATION

The Chair: The next presenters are the Canadian Drug Manufacturers Association, Julia Tam, Brenda Drinkwalter and Jack Kay. Welcome to our committee.

Mr Jack Kay: Thank you for the opportunity to appear before this committee. My name is Jack Kay. I'm chair of the Canadian Drug Manufacturers Association. With me is Brenda Drinkwalter, the president of CDMA, and Julie Tam, a pharmacist and our director of professional and scientific affairs.

The CDMA represents the Canadian-owned pharmaceutical manufacturers that specialize in the production of high-quality, affordable generic prescription drugs as well as the research and development of innovative pharmaceuticals. CDMA member companies employ close to 4,000 men and women in communities across Canada and spend over 13% of their sales on research and development in this country.

Canadians and Ontarians value the high-quality, affordable medicine that has been a cornerstone of our public health care system for over a quarter of a century. Through our research, development and manufacturing activities, CDMA member companies are making a strong contribution to the advancement of our health care system.

The Ontario-based CDMA member companies are a strong and emerging force in the domestic and international pharmaceutical industries. CDMA companies employ nearly 3,000 Ontarians in a variety of sophisticated, high-tech positions. By comparison, only five years

ago there were less than 1,300 employees in the Ontario generic sector. Spending on R&D is expected to reach \$350 million in Ontario over the coming three years.

The level of usage of generic drugs in Ontario has traditionally been higher than elsewhere in Canada because of the favourable provincial drug substitution laws. However, recent changes in the government drug programs of other provinces to favour the use of generic drugs and their increased use by third-party payors has increased the overall generic presence in Canada.

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Currently, 41% of all prescriptions filled in Ontario are with generic drugs. Because of lower prices, generics represent only 13.4% of actual dollars spent on prescription drugs in Ontario.

Generic products are of the same quality as brand-name drugs manufactured by the foreign-owned multinational drug companies and must meet the same stringent standards established by the health protection branch of the federal Department of Health.

In Canada, according to the latest IMS Canadian drugstore and hospital audit, generics represented 37% of all prescriptions filled in Canada. In terms of pharmaceutical sales value, the generics are much smaller because of the low prices we charge for the products. For the first half of 1995, generics accounted for 12% of prescription dollar sales. A comparison of brand and generic prices for the top 25 genericized products in 1995 shows that, on average, generic products are priced 42% less than their brand-name counterparts in Ontario.

A recent study by CDMA, called *Generic Drugs: Savings to Canada's Health Care System*, showed that generic drugs save Canadian purchasers \$750 million annually. This represents a savings of more than 13% of the total annual drug bill in Canada. Given that Ontario represents approximately 40% of the Canadian total market, savings in Ontario due to generic drugs could be up to \$300 million.

The importance of this saving is highlighted by the fact that drug expenditures are now the second-largest category of health expenditures in Canada. Expenditures on drugs continued a decade-long trend of having the highest level of growth of all categories of health expenditures. Expenditures for both prescription and non-prescription drugs increased from 8% of total health care expenditures in 1977 to 15% in 1993. The Green Shield Report on Drug Costs concluded that the main reason for this increase was the shift to new, higher-cost drugs from older, lower-cost drugs which have been genericized.

Once a generic product is on the market, it is very rare that its price ever increases. Typically, prices decrease over time as more competitors enter the market. The 1995 IMS study *Generics Canada* shows clearly that more competition brings the price of generic products down. When a product is available from one generic manufacturer, the generic price is equal to 79% of the brand. This falls to approximately 54% of the brand when four companies are marketing the same drug.

The message then is clear: Generics are an important part of the solution to rising drug costs. The more efficient and effective the process of bringing generic drugs to market, the greater the savings. The potential for

generic drugs to bring even greater cost savings depends, in a large measure, on government policy and practice.

Ms Brenda Drinkwater: Now we would like to comment on the proposed changes to the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act under Bill 26.

The CDMA recognizes the importance of this government's efforts to limit the cost of the Ontario drug benefit program. At the same time, we would emphasize to government the need to safeguard the interests of all Ontario consumers, not just those where the government pays the bill.

Pharmaceuticals are essential goods. A diabetic, for example, cannot simply decide that he or she will not purchase their insulin if the price is too high, or a diabetic cannot decide to purchase a high-priced insulin and stretch its use over a longer period by reducing the dose. These are choices a consumer can make if purchasing other commodities, for example household appliances, gasoline, food or cars. That is why governments in most industrialized countries intervene in the pharmaceutical marketplace with measures to protect their citizens.

Our comments today will focus on areas of the bill that we support, together with improvements to the bill that we feel are necessary to maintain the appropriate balance between the interests of consumers, employers and governments, who pay for drugs, and the pharmaceutical industry, that makes an important contribution to the economy of this province. Specifically, we are going to address the areas of no-substitution prescriptions; mandatory substitution provisions; interchangeability off formulary; accelerating the approval of cost-saving generics; copays and deductibles; the minister's power to set prices; and price deregulation in the cash marketplace.

With respect to no-substitution prescriptions, the CDMA commends the government for eliminating the previous rule that enabled a doctor, simply by writing "no substitution" on a prescription for an ODB patient, to force the taxpayers to pay for a brand-name product even though a low-cost and effective generic product was available. Brand drug companies' promotional efforts are often targeted at thwarting substitution of low-cost drugs in the interests of protecting market share at the consumers' expense. The proposed legislation does not restrict a physician's right to prescribe a drug; it only limits the amount the government will pay.

With respect to mandatory substitution, the CDMA also commends the government for maintaining mandatory price substitution, that is, a statutory rule requiring that, absent certain exceptions, the pharmacist must dispense the lowest-cost product in his or her inventory if the drug is a multisource product. This keeps the cost of drugs reasonable for Ontario's citizens, who are often not knowledgeable enough to make meaningful price comparisons.

We will now turn to areas where the CDMA believes that the bill can be improved by way of amendment to the benefit of all consumers in the province.

The previously mentioned principle of mandatory substitution as structured in the bill does not extend to all drugs for which an equivalent generic is available. The

regulations to the bill must be structured to ensure that consumer savings are maximized.

Regulations under the Prescription Drug Cost Regulation Act currently specify that a generic drug cannot be designated as interchangeable and substituted unless the brand product is an ODB benefit, that is, that government pays for that product on the formulary. Many brand products are not listed today in the formulary because the government thinks they are too expensive or in some cases because the brand company has decided not to list the product, effectively blocking competition from the lower-priced generic. This means that for an increasing number of products, Ontario consumers have no effective access to lower-cost drugs, even though they are available and consumers in other provinces enjoy savings from those same products.

Let me highlight this for you with an example which you have in your briefs. A patient may be diagnosed with a chlamydia infection. The doctor then prescribes Vibramycin, a brand name; doxycycline is the generic equivalent. Even though there is a generic doxycycline available, the pharmacist cannot interchange it and will dispense the brand-name Vibramycin, which costs 168% more. Why is the generic not interchangeable? Simply because the government doesn't list the brand as a benefit in the ODB program. With a regulatory addition to Bill 26, this can be changed and the patient will only have to pay 63 cents a tablet instead of \$1.69.

The report of the Pharmaceutical Inquiry of Ontario, the Lowy commission, recommended in 1990 that Ontario address this regulatory problem with urgency. Regulatory changes were drafted, finally, in the spring of 1995 to effect this long-overdue change. While employers, insurers, pharmacists and this sector of the industry gave strong support to this regulatory change, it was opposed by the brand-name industry, which would lose market share if competition from generics was not prohibited by this unintended regulatory problem.

We submit that the regulatory change to permit interchangeability of drugs not in the drug benefit formulary be embodied in the regulations to the Drug Interchangeability and Dispensing Fee Act without further delay. This would provide savings of \$26 million to Ontario consumers at no incremental cost to government. The government has a duty to ensure that its regulations do not inhibit but encourage access to low-cost drugs for all Ontario consumers.

The Ontario government could achieve major savings to the ODB plan simply by eliminating pointless regulatory delays in getting new generic products on the formulary. New generic products should be designated as interchangeable automatically and immediately after receiving approval from the federal government. This has been the case in other provinces for many years.

CDMA conducted a study of the provincial formulary approval times for those products that were recently added to the ODB formulary as of September 1, 1995. The time taken to gain entry to formularies in various provinces was compared for identical submissions. Median times for formulary acceptance are set out in your brief, but they ranged from 16 months in the province of Ontario to as low as one month in the

province of British Columbia. We calculated that Ontario consumers overpaid \$6.2 million for brand products solely as a result of these delays, even though a generic existed and was available in other provinces.

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In the spirit of assisting the government with streamlining the regulatory process, CDMA prepared a thorough legal analysis in September 1995 of the changes required to simplify the Ontario process so it would be as efficient as the process in other provinces. This would maximize savings not only to the drug program but for all consumers. We have copies of this report available if it would be useful to members of the committee. In this time of fiscal restraint, the bill and its regulations should be structured to incorporate these changes without delay.

The CDMA is also concerned about the proposed copayment and deductible schedule. It may prove to be a financial hardship for seniors and those receiving social assistance. It focuses unfairly on pharmacists' dispensing fees. CDMA believes that the government should seriously investigate the alternative copayment schedules proposed by these various organizations.

With respect to the ministerial power to set prices, the changes significantly increase the government's power to set the price of prescription drugs on the formulary, contrary to the briefing documents which suggest that the market is being deregulated. Proposed changes in the bill are intended not only to give the government sweeping powers to set prices but also to give no effect to the previous decisions of the courts that pricing policies have been unlawful.

The CDMA believes it is unfair for the government to attempt to retroactively undo proper legal decisions. We also question whether the government has the legal authority to completely shield itself from judicial interpretation, as this bill attempts to do.

The CDMA believes that giving the government the power to set prices is somewhat counterproductive. It appears that the change is intended to give the government the power to compel new generic manufacturers to give prices below those of previously listed brands as a condition of being listed as interchangeable.

Setting introductory formulary prices for generics is unnecessary and arbitrary for products which are, by definition, competitive commodity goods. Arbitrary processes also give rise to costly litigation, which CDMA views as a waste of both corporate and taxpayer resources.

We do not feel it is logical, and feel it is a complete waste of taxpayer money, for the government to refuse to list a generic because it is not offered at an arbitrary 75% of the brand-product price. If the government is already paying \$1 a tablet for the brand-name product, it doesn't make sense to deny listing to the generic and to continue to pay for the high-priced brand product simply because the savings are not as large as the government would like. The generic should be listed if it comes in at 90 cents, 75 cents or 50 cents. The ODB program needs to realize savings wherever it can.

Generic prices will often be priced considerably less than 25% below the brand product due to competitive pressures in the marketplace. The CDMA recently did a

study of the prices in Ontario of all 57 non-formulary generics where the prices were not regulated but, rather, set by the marketplace. It found that prices were on average 33% lower, even though competition was very limited; in most cases there was only one generic.

Unilateral government action to set prices ignores the generic manufacturers' costs and risks, which will vary from product to product; it ignores the marketplace situation. Setting prices could make it uneconomic to produce new generics or reduce the incentive to bring them out quickly. Price freezes, for example, have already created situations where generic manufacturers are forced to sell below cost. Their exit from the market would leave the government only the high-priced brand, often priced at many times the generic, and it would be forced to incur costs well above what it is presently incurring.

The way to achieve lower prices is to list generic equivalents of as many products as possible on the formulary as soon as possible and to encourage competition and investment in new generic products. Generic manufacturers compete vigorously with each other and studies show that the more generic manufacturers competing for market share, the lower the price. New powers to set price will more likely lead to arbitrary interference in the market, costly litigation and paralysis of the competitive forces that have worked well to bring prices down.

With respect to price deregulation in the cash marketplace, the wording of subsection 7(2) of the Drug Interchangeability and Dispensing Fee Act appears to deregulate the price of non-ODB sales of monopoly brand-name products only, products that are the most expensive and where the consumer exposure is the greatest. This section says that if the dispenser supplies an interchangeable drug, that is, where there is generic competition, then he or she:

"shall not charge, in addition to the dispensing fee, more than the lowest amount the dispenser would charge for the product dispensed or the products that are interchangeable with it in the dispenser's inventory."

We interpret this to mean that the pharmacists cannot charge a consumer more than the lowest amount he or she would charge any patient, which includes an ODB customer, for a particular multisource drug. While "amount" remains undefined, it would appear to refer to the drug cost component plus markup. The proposed wording is difficult to interpret and should be clearly specified as in the previous PDCRA section. The wording should clarify that the pharmacist is obliged to charge, in addition to the dispensing fee and markup, an amount no more than his lowest acquisition cost for an interchangeable product in his inventory.

CDMA supports the limited consumer protection offered by section 7, as we believe that all Ontarians deserve full cost savings available from generics. In the absence of price competition from generics, consumers must have access to fair and reasonable prices for drug products and markup percentages.

In conclusion, we would suggest that Bill 26 fails to address the significant opportunities for realizing savings in drug costs for Ontario consumers. It appears to take aim at the domestic industry, unnecessarily increasing the

government's power to regulate the small generic sector, which represents only 13% of the market, where competitive market forces are adequate and even superior to regulation in controlling costs. It is noteworthy that the foreign-owned multinational sector responsible for the lion's share, 87%, of the drug bill lauds the government for the bill. They must expect somehow to be a beneficiary of these changes. We ask, at what cost to Ontarians?

The bill, in the structure of the copay system, unfairly targets pharmacy, who have an important contribution to make in controlling drug costs through patient counselling and in particular controlling inappropriate drug utilization.

The total lack of consultation in crafting Bill 26 and the absence of interpretive regulations has resulted in legislation that puts at risk the delicate balance that must be maintained between the interests of the province's consumers, governments and employers who pay for drugs and the province's pharmaceutical industry that makes an important contribution to the economy of this province. These changes should be suspended pending a thorough regulatory impact analysis and a comprehensive consultation process on the effect of this bill on all parties.

Thank you very much, and we would be happy to answer your questions.

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Ms Lankin: Mr Chair, we're over halfway through the hearings, and I have to tell you, with respect to this section of the act, I am totally confused. I don't know what it says and what it means, and I think you know that I have been attempting, through asking questions, to figure it out.

I have to tell you, I appreciate your presentation, but boy, you've got me overwhelmed at this point. I asked questions of every brand-name company that came forward and of the Ontario division of PMAC and spent some time off the record trying to talk with someone who knew more about this than me to explain it to me, and got the sense that what would happen is—well, the government thinks it's going to negotiate a big deal as a big purchaser. In terms of brand-name drugs, that price is already regulated through the Patented Medicine Prices Review Board and that price wouldn't change, so there wouldn't be a saving there, but the real big savings would come on the generic drugs for government, and what you charge us for generic drugs here in Ontario is substantially higher as a proportion of patent medicine prices than you do in the deregulated free market in the United States. This is what I was led to understand. You might want to respond to that.

But now you're telling me that the way you read this act, if the government gets a really good price with you because it's a big purchaser, for an interchangeable product, the pharmacist will have to charge that same low price to everyone else. I don't know what you're going to charge the pharmacist, yet there isn't a control on the patent—if everyone else is confused, you're with me on this. I'd like to have representatives of both parts of the industry in front of us and hear them debate this so maybe we can figure out, before we get into trying to deal with amendments, what this is all about. But if you can help me understand it, I would appreciate that.

Mr Kay: The reality is that prices in Canada, whether it be from the multisource industry, the CDMA, or from the brand industry, are really set across the country. There are no price differentials that the government or consumers in Ontario pay from what consumers will pay in the province of British Columbia. So as far as the changes go, there will not be savings to the Ontario government by saying they are going to negotiate generic prices, because generic prices are set at a national level.

The other important thing to remember is, at this point in time, generic prices are frozen. We cannot increase our prices. Hence, we are very hesitant—and in fact as a business person we cannot afford—to give the Ontario government lower prices on certain products, because we cannot increase prices on other products.

As an example, there are several products within the Ontario drug benefit formulary that the generic industry has listed and we are losing money on those products. I will give you the example of a drug called sulfinpyrazone where the generic is listed as \$6.61 a hundred. We lose money on every bottle that we sell in the province of Ontario. The brand-name is listed at \$31.55 per hundred. If we delist our product from the formulary, which we are considering doing, then the Ontario government will be paying \$31.55 per hundred tablets. We have asked the ministry to at least allow us increase our price to cover our increased raw material prices to \$15 per hundred, which is still half of what the brand is charging the government. Hence, we'll remove the product from the formulary, the government will pay \$31.55 and at this time it's paying \$6.61. It is illogical.

Mr Clement: Just parenthetically, it really isn't unusual for different players in any particular industry to read legislation, or proposed legislation, from a different perspective, and people can I think legitimately disagree over what hundreds of current bills say, let alone what proposed bills say. So it doesn't surprise me nor alarm me that there are differences of interpretation between what we're hearing today and what we heard before Christmas.

I did want to try to shed some light through our discussion about this, though. First of all, on the no subs rule, we've heard a lot of commentary in the past about how a no subs rule will inevitably mean that patient care will suffer, because even if generics and brand names are chemically identical, they can affect patients in dissimilar fashions, which quite frankly did alarm me when I heard that kind of evidence before this committee. I'm just a lay person on this, so I don't have any background, but is that a valid argument or is that an invalid argument?

Mr Kay: It's an invalid argument. It's a spurious argument. In fact, if you look at the sales of generic drugs in Canada, many of the generic products available in Canada are in fact manufactured by the brand industry itself and sold under a different label.

If you look at the history of the generic industry since 1969, when it really evolved into the industry it is today, the only complaints about generic substitution have been anecdotal complaints. There is no scientific validity to say that because of the non-medicinal ingredients we use in the manufacturing of our products, there is going to be

an untoward effect on the consumers in Canada. There are just no scientific data.

Mr Clement: That's comforting to know. Can I just refer you to your conclusion, where you ask rhetorically—I don't mean that pejoratively when I say that, but it was a question in your presentation—why the foreign-owned multinational sector would be happy with deregulation. Can I probe this way and say you represent a number of generic companies and other companies. If I asked you, are you ready to compete in the marketplace, your answer would probably be: "Absolutely yes. We're here to compete. My company can compete with the best of my competitors and is a darn sight better than the rest of my competitors." Wouldn't the drug manufacturers have the same sort of analysis, the brand names?

Mr Kay: The brand-name industry with monopoly products does not compete with other brand-name companies. They have exclusive products. They might all have products in the NSAIF area, which is non-steroidal anti-inflammatory. When they are monopoly priced, they are high-priced. The only time competition comes into a chemical entity is when it is genericized and where it—

Mr Clement: That's why we have the patent medicine review board federally, though, isn't it?

The Chair: Thank you, Mr Clement. Ms McLeod.

Mrs McLeod: I begin by saying that Mr Clement may not be alarmed, but I am extremely alarmed that no one, least of all the government, has any idea what deregulation of drug prices is going to mean either to the government's cost of providing the ODB or to the individual consumer of drug products. I wholeheartedly support the final lines of this presentation that say all these changes "should be suspended pending a thorough regulatory impact analysis and a comprehensive consultation process."

Having said that, I will therefore ask you, because I share Ms Lankin's sense of we just cannot get a clear picture of the cost impact at this point, the only thing that's clear in my mind is the Minister of Health suggesting that the way in which consumers will respond is to go from pharmacy to pharmacy bartering for the best price in drugs. That stays very clear in my memory.

I'd like to ask you about the copayment implication. You cited the Green Shield study on utilization, and there was another figure that was presented to us this week that 15.1% of the increase in utilization was due to an increased quantity being prescribed per claim. We've seen other data from other provinces that say if there's a large quantity on any given claim, there is a lot of wastage and therefore the total utilization will go up. There's a concern then that seems to follow that if the copayment scheme is brought in and physicians and pharmacists, in wanting to minimize the effect of the copayment for people on limited incomes, prescribe larger quantities per claim, that could lead to greater utilization and therefore, ironically, to a greater cost for government of the ODB plan. Is there a logic to that?

Ms Julie Tam: There is a logic to that. In British Columbia, where the same copay system is used—in British Columbia, the senior has to pay 75% of the dispensing fee—they have three times the size of the average number of days on a prescription that they do in

Ontario. British Columbia has identified that people getting large numbers of prescriptions lead to inappropriate taking of the prescription or out and out usage. You get a new prescription from the doctor and the doctor writes "for 100 days," you take it for 15 days and you don't like the side effects, so you don't take it any more and then you waste the rest of the prescription. So this copayment schedule, where in Ontario they're saying you have to pay either the pharmacist's fee or \$2, will probably lead to people choosing to get larger amounts in every one prescription in an effort to save \$2, but meanwhile the government or whoever has to pay much more in the cost of a drug just so the person doesn't have to pay the extra \$2. It doesn't make sense.

The Chair: Thank you for your presentation. We appreciate your interest in our committee process.

Ms Lankin: Mr Chair, may I table a question, please? I'm wondering if the ministry would attempt to provide members of the committee with a detailed briefing note with respect to the Drug Interchangeability and Dispensing Fee Act, and I think in particular price deregulation and the cash market, as well as some of the issues that have been raised with respect to the differential purchasing power of the government with respect to patented drugs and generic drugs, to explain that in greater detail from the ministry's perspective for members of the committee. I've looked in the book and the briefing notes that have been provided and they are not sufficient to help me to understand the intent and the potential impact of this section. I think all committee members might benefit from receiving that.

Mr Clement: On that same point, Mr Chairman, with due deference to Ms Lankin, I think the procedure is if she has specific questions, the ministry is quite happy to accede to her request. That's pretty broad.

Ms Lankin: If Mr Chair would like to give me the time to put all the specific questions out, when he chastised me yesterday for taking too long to do that, I think people know the kinds of questions I've been asking. I'm just asking for the ministry's advice to us with respect to that, and I think you would want to facilitate that, not block members from getting access to ministry information.

Mr Clement: No, no. I'm not blocking anybody. I'm just asking for specifics.

The Chair: Mr Clement, the question is in order.

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CANADIAN MENTAL HEALTH ASSOCIATION, OTTAWA-CARLETON BRANCH

The Chair: The next presenters are the Canadian Mental Health Association, the Ottawa-Carleton branch. Good afternoon and welcome to our committee. You have half an hour of our time.

Mr Mark Parsons: Thank you for inviting us today. I hope we will have time for questions. We'll try to keep this to 15 minutes so we'll have some time. My name is Mark Parsons. I'm a board member of the Canadian Mental Health Association of Ottawa-Carleton. On my right is Joanne Lowe, the executive director of that same Canadian Mental Health Association, and on my left is

Bill Carne, a board member of the Psychiatric Survivors of Ottawa.

We, Joanne and I at least, are here today representing the Canadian Mental Health Association of the Ottawa-Carleton branch. CMHA is a non-profit organization involved in planning for the delivery of services for people who have a serious mental illness. Directed by a community board, CMHA is partnered with members of the community, including consumer-survivors and family members, other community agencies and government representatives.

Our focus today is on the impacts that the provincial budget and Bill 26 will have upon the lives of people who experience a serious mental illness. To understand the impacts of these proposed changes, and the changes that this government has already introduced in Ontario, have upon individuals with a psychiatric disability, it is important to first understand the nature of psychiatric illness.

Mental illness can be defined as a medically identifiable disability that includes a group of symptoms that can affect a person's thinking, feeling or relational abilities. Illnesses include schizophrenia, depression and manic depression. The symptoms of these mental or psychiatric disabilities are often invisible, not visibly apparent in the same way many physical disabilities are. They are persistent or chronic and they are episodic, in that many symptoms may be alleviated for a period of time, only to recur in times of stress or hardship—like today I guess, for me anyway.

The effects of mental illness—I'll try to keep sane through the whole thing—

The Chair: Do you want to change places with me maybe?

Mr Parsons: No, I do not, though I wouldn't mind the salary, I think.

Interjection: You might be surprised.

Mr Parsons: No, you'd be surprised at what I earn, I think.

The effects of mental illness also include a cluster of other potentially debilitating factors, such as fatigue and exhaustion, and the stress brought on by the stigma and hardships associated with having a psychiatric disability. One of the most pressing hardships is the economic reality of living in poverty that many people with a psychiatric disability face. The episodic nature of psychiatric disability makes it very difficult for many people who have a mental illness to secure and maintain consistent employment, especially in the competitive job market.

The symptoms of mental illness can be managed in various ways, including therapy, medication and support. Physicians and psychiatrists provide medical treatment and community services such as case managers, outreach workers and peer support also provide the necessary support for a person in order to prevent recurrence of symptoms. A range of service from informal support such as family and friends to more formal community support such as supportive housing and crisis intervention to formal treatment such as hospital care is often required for people with a mental illness.

Our focus at CHMA is on community supports. We believe that a full range of services available in the

community are necessary to maintain mental health and prevent recurrence of illness and costly hospitalization.

People with psychiatric illness require more than the formal mental health services of hospitals, community agencies and private practice. A new framework for support prepared by CMHA national outlines the integrated community resource base required to live a health and fulfilling life. Jobs or other productive activities, shelter, food and adequate income are all basic necessities to both physical and mental health.

The recent cuts have had serious negative impacts on the lives of many people with a psychiatric disability. This government, prior to and since its spring election, has stated clearly that any economic cuts brought in by the government in its attempt to reduce the deficit would not affect people who are disabled, that people with disabilities would not be penalized.

We are here today to tell you, like many others in Ontario have already told you, that the changes you have already introduced, and those you introduced in your budget statement and through Bill 26, do in fact penalize people who are disabled. Most individuals who have a psychiatric disability are on some form of social assistance. Individuals who have been formally diagnosed by a doctor may be receiving family benefits allowance. There are many people who have a psychiatric illness who are only receiving general welfare assistance because they do not want the label of being permanently disabled, for example, and their application for FBA has not been processed, or for other individual reasons. There are many reasons not to end up on FBA and live on general welfare.

Today we will give you some background information specific to Ottawa-Carleton and speak to you on the implications of hospital restructuring, the proposed changes to the Ontario Drug Benefit Act and access to personal information. I'll ask Joanne to do that for us.

Ms Joanne Lowe: Although we acknowledge that the health services of Ontario can be delivered in a coordinated fashion with less financial cost, service change or reduction in one part of the health sector system will impact many other areas of the community and must be planned for and managed in a manner that will prevent long-term, greater economic costs. It is critical that any restructuring or reviewing of both hospital-based and community-based mental health services be done in partnership with consumers, family members and providers in the local communities affected.

While there are common issues that affect most people with a mental health problem, each community is unique in many ways. In Ottawa-Carleton, consumer-survivors and family members are a critical component in the mental health planning process. We have a planning and decision-making structure in place, and although, like all decision-making structures, it can be improved, we feel strongly that this government needs to respect the individual integrity and uniqueness of each community it represents. The proposed Health Services Restructuring Commission and any other process or structure for government decision-making must have input from stakeholders and be partnered with local communities.

The pressure on family members and community support services will be more than they are able to cope with in the current level of resources and funding in our community. The cutbacks to hospitals and the focus on core hospital services will put pressure on hospitals to be closing psychiatric services. If hospitals are unilaterally closed, there will be an extra burden for family members to care for individuals whom they might not have had the resources or ability to care for. Family members can attest that it is extremely difficult to manage when a son or daughter or spouse is experiencing severe symptoms of mental illness. Hospital care and treatment are currently the only resort in Ottawa-Carleton when someone is in crisis.

At CMHA we recognize the need for hospital restructuring and support efforts to do so. In the area of mental health services, the restructuring process has already begun. All that is necessary at this stage is for the government to move strongly toward mental health reform. The demand for and pressure on community-based mental health services has never been so great in Ottawa-Carleton as it is at present. Currently in Ottawa-Carleton, \$120.8 million is spent on mental health care each year. Only 4% of this amount is spent on community mental health services, such as case management and outreach services. The remaining 96% is spent on hospital services, salary and professional fees and OHIP billing.

There is a current imbalance in the range of community and hospital services in Ottawa-Carleton. This current imbalance will not be rectified by providing the Minister of Health with the power to unilaterally close hospitals. The reallocation of resources to the community is not likely to occur in this event, and our expectation is that any saving from hospital restructuring be allocated directly into our own community. Appropriate and necessary services in the community close to where a person lives can prevent costly emergency crises and rehospitalizations. Some of these community supports would include case management, emergency services, psychiatric rehab services, and the list goes on and on.

1510

One of our main areas of concern regarding the recent budget announcements and the proposed Bill 26 are the proposed changes to the Ontario drug benefit and Trillium drug plans. Our concerns are not just philosophical, but very practical. People with a psychiatric illness often require multiple, ongoing prescriptions. While it may not seem a lot to someone who has an adequate income and does not require ongoing medication, the \$2 copayment for prescriptions is more than people with a psychiatric disability are able to bear.

Many people with a psychiatric illness require ongoing medication to manage their symptoms, and for many individuals with a psychiatric illness, taking medications daily is part of a necessary lifelong routine that enables them to stay well. Without medication, many would become sick again and would need to be rehospitalized. Further, it is not uncommon for one person to need more than one different medication to combat either the illness itself or to counteract side-effects of the other medications. One person we spoke to yesterday has four prescriptions she will have filled out each month; another

has seven prescriptions monthly. This number is not uncommon.

During times of crises, individuals will see their doctors more often, perhaps weekly or even twice a week. Doctors will often only provide enough medication and prescription to last until the next appointment, in order to monitor the effects of the medication and the symptoms of the illness. Weekly amounts of medication will similarly be prescribed when a medication is being introduced to a patient so that the impacts of the side-effects of the medication can be closely monitored and the dosage adjusted accordingly.

These are important reasons for discouraging the provision of more than a month's prescription at a time. A person who is experiencing a recurrence of the illness or being introduced to a new medication therefore may easily have between 10 to 20 prescriptions in a month. This is not to say that even an ongoing cost of two or three medications is a cost that can be accommodated for someone who experiences a mental health problem on a fixed income. For individuals with a psychiatric illness who are living in a supervised boarding home, for example, this fee needs to come out of their \$112 "comfort" allowance, the only direct income they have each month. For everyone on social assistance, the additional cost of prescriptions will be difficult to bear.

The changes to the drug plans and legislation will deny and restrict people's access to necessary medication. They will restrict people's access through introduction of user fees. Staff at CMHA have just in the last week talked to two people who had no money for the bus to get to the drugstore to get their prescriptions filled. One person had two prescriptions, the other one had three. Both individuals spoke about their concerns about the \$2 copayment, stating that they would not be able to afford it and stating that they just wouldn't bother to get their prescriptions filled.

This change to the Ontario drug benefit plan unjustly targets people who have chronic illness requiring medication. These are individuals who are most in need of financial assistance. They certainly do not have disposable income that can accommodate this burden.

The impact of introducing this \$2 copayment to people with a psychiatric illness will be that some people will not get their prescriptions filled; they will get more sick and quite possibly require hospitalization. The changes to the drug plan will also restrict access to necessary medication. We also have strong concerns regarding the province no longer cost-sharing, through municipalities, the discretionary provision of drugs and drug-related products through supplementary aid or special assistance.

In Ottawa-Carleton, the region will not be able to pick up this difference. The working poor will not be covered, and for those who have a mental illness who do not work for pay, many of them will have part-time or episodic work and will be living on very low income. This will impact upon them, as their costs of medication will no longer be covered through supplementary aid and special assistance.

The proposed changes regarding no-substitution claims are also of strong concern to us. The government needs to recognize that when a prescription is labelled "no

substitute," it is because that particular medication is what is required, not an interchangeable one of a lesser price. Medications for people with a psychiatric illness are very precise. When no substitution is indicated, it is because generic products or brand-name products are not suitable. People do not do as well on a generic drug. A change to what seems to be similar medication can result in serious side-effects. The individual should not have to pay the difference, and the difference needs to be covered under this drug plan.

When a new medication is brought to the market, it takes time, often years, before a generic or a substitute drug is developed. Not covering the medication under the drug plan will restrict people's access to treatment that they may need quite significantly.

The changes in the conditions of payment proposed by this government could restrict payment for specific drugs to situations where clinical criteria have been satisfied—a specific illness or that other treatments are ineffective, for example. We have questions and concerns regarding what the clinical criteria will be.

Who will determine the criteria that must be satisfied and how criteria will be determined as being satisfied? CMHA Ottawa-Carleton strongly believes that the most effective treatment is determined best by the mental health consumer with their doctor and other health supports. Client/patient self-determination of their own treatment is paramount.

CMHA Ottawa-Carleton supports the recommendation of the Ontario division that drugs prescribed for psychiatric illness be exempt from the deductible and the \$2 copayment. There needs to be inclusion in the drug plan of medication which counters the side-effects of other medications and prescriptions.

While it may appear in the short term that there will be cost savings through the proposed changes in Bill 26, it would be irresponsible not to take into consideration the long-term expenses associated with increasing numbers of rehospitalizations and the use of other services as a result of these cuts at the front end.

The provincial cuts to social assistance and the reductions to municipal transfers have already impacted people with a psychiatric disability. While many individuals with a mental illness receive the family benefits allowance, there are those individuals who are on general welfare assistance and have been cut by the 21.6% in their income.

As well, some individuals with a psychiatric disability are able to work part-time or periodically. They are among the working poor. Community supports such as non-profit and subsidized housing, outreach and case management services, counselling, special assistance and supplementary aid, transportation, supportive employment services, emergency shelters and emergency food are basic supports in many of these individuals' lives. All of these community supports have been reduced or are in severe jeopardy due to the provincial government cut-backs.

Cuts to non-profit housing mean less adequate and affordable housing and cuts to social services mean less supports for people to maintain this housing. For people with a mental health problem this can mean the differ-

ence between having shelter and living on the street. Cuts to municipalities have also meant that local government is less able to provide grants to emergency shelters, drop-in centres, food banks and other critical services with people with mental illness.

Currently, the emergency shelters in Ottawa-Carleton are full to capacity. Food banks are having to turn people away because of the tremendous demand. The stress associated with living in poverty and being vulnerable to homelessness and hunger has increased severely among consumer-survivors of Ottawa-Carleton. This stress exacerbates symptoms of a person's illness.

Mr Parsons: We actually get to the closing remarks now. Isn't that fabulous? Although Joanne did a wonderful job.

To summarize, we would like to leave you with a set of illustrations on how the changes already introduced and proposed changes impact upon people with a psychiatric disability.

We have a really nice diagram. This is Joe—he's up in the top left-hand corner—and he lives in a boarding home, so his housing and food are provided for him. He's given meals and he's given a room to live in and he gets \$112 as a personal needs allowance, often called a comfort allowance.

But poor Joe, although he gets his food and a nice room somewhere, he has to pay for his transportation, and in Ottawa-Carleton that's \$57. He has to pay for his copayment on medication as well, and that's an extra \$14 for a stable person receiving medication. For all his clothing and personal care, his haircuts, his cold medicine, any coffee he wants to buy, doing his laundry, things like that, he would then have an extra \$41 in a month to achieve all this. That's poor Joe's life experiences and what some of these changes would do for him.

1520

Ms Lowe: This is an illustration of what life would mean to Jane currently, and on top of that, the proposed changes that would come out of Bill 26 and the provincial cuts that have already taken place. Jane is on FBA. She receives \$920 a month. She lives in a bachelor apartment for which she pays \$522 a month, which is a fairly conservative figure for an apartment in Ottawa-Carleton. She pays \$170 for food on a monthly basis. Her transportation has just gone up by \$3 a month this year, up to \$57, and for her telephone, her hydro and her cable, it's about \$38 a month. For her medication, there's the new charge of the copayment if she gets four prescriptions a month, which is a fairly conservative figure for Jane, times \$2. For other expenses she's left with \$125 to buy clothing, to meet personal care needs that would include soap, toothpaste, shampoo, cold medicine, laundry and entertainment. That's what life looks like for Jane under the circumstances.

Mr Parsons: To conclude, we strongly urge that in review of Bill 26, this government recognize the critical needs of people with a psychiatric disability; that it support the process and principles of mental health reform, which will strengthen the community's ability to respond to people's mental health needs; that it consult and plan with community stakeholders, especially consumer-survivors and family members, in developing and

restructuring the mental health care system; that it not proceed with the amendments to the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act until a more comprehensive review and consultation is completed; that it provide for access to the treatment and medication necessary to alleviate the symptoms of mental illness.

I'd like to thank you for the opportunity to provide comment on Bill 26 and the impacts the proposed changes in this bill will have within the lives of people with a psychiatric illness. We hope this government seeks out the input of many community members, especially client groups, whenever it intends to introduce changes in Ontario.

I understand that many other groups wished to speak to this committee while you were in Ottawa but have not been able to do so. We hope that everyone will have the opportunity to have their views heard by you before you have finished this hearing process.

Now I'd like to introduce you to Bill Carne. He's a board member of the Psychiatric Survivors of Ottawa, who have asked him to speak on behalf of confidentiality.

Mr Bill Carne: Thank you for hearing concerns on mental health issues. I also would like to thank the Canadian Mental Health Association, Ottawa-Carleton branch, for giving me some time to speak. CMHA Ottawa is very supportive of psychiatric consumer-survivors in Ottawa.

My organization is the Psychiatric Survivors of Ottawa. We receive Ministry of Health funding to provide supports to consumer-survivors. As many of our members offer a lot of volunteer time, we provide great benefits for little cost, and our funding is coming up shortly.

Our main issue is that of confidentiality of patient records. I would like to open by making you aware that the issue of confidentiality of patient records affects you personally. It is the clinical records of you and your family members that are also affected by the proposed changes. If these records were to include issues such as mental illness, AIDS, abortion etc, and this information were made public, it could possibly be very damaging to your chances for re-election. You thus see on a very personal basis the importance of having strong safeguard procedures and policies in place to prevent abuse and accidental release of this information.

Confidentiality is a major issue for people with a psychiatric history. For example, the return address of all correspondence sent by our organization does not include our name. If someone were to call our office asking for a member, we would advise the caller that we will contact that person, if they are a member, and that person can, if they so choose, return the call.

We have very deep concerns about the possible impact of people being fearful of full disclosure of whatever they say to their doctor. Already we have been advised by some of our members that they're not raising key issues with their doctors for fear that information will become public, yet unless they give full disclosure to the doctor, they cannot receive the treatment they need. As well, you're aware that the confidentiality of information by battered women is already an issue.

A Ministry of Health spokesperson on a local radio show said the changes were to be done to update an old act, that many new payment methods have come into place other than fee-for-service and to be accountable for the money the ministry is spending, a means to prevent fraud and misuse of the system is necessary. While we agree with this in principle, we are not sure this method is the best process to achieve this.

You're aware that the Information and Privacy Commissioner has already expressed very serious concerns about the wording and possible effects of this act as it stands. We ask you to consider his concerns when redrafting this part of the act.

We suggest that what you propose as regulations for safeguards be actually put into the act, making it harder to make changes to these protocols. We suggest that a penalty for disclosure, even accidentally, be put into this act. If possible, we would like it to be illegal for the press to release any information obtained by disclosure of this information.

I emphasize very strongly that if you have a psychiatric history, the stigma is extremely great. There are many working people, with real jobs, who, if it were found out they had a psychiatric history, might lose those jobs. Myself, I acted as an advocate for about a year and a half before I was willing to go public to my friends and things like that.

Finally, we are not too sure how you would decide what files are to be chosen for examination. At present, it just seems to be on a hit-or-miss basis. As a suggestion, perhaps there's a means to, say, compare OHIP and WCB files by patient number and date to find possible causes of abuse.

Thank you very much for your time.

Mrs Ecker: Thank you very much for coming and for an excellent presentation. I agree with you that confidentiality is an extremely important principle, especially in the mental health field. It is my understanding that section 8 of the Mental Health Act, which does have specific provisions for what can and cannot happen, makes the Mental Health Act supersede any other legislation. If there were anything in 26 that would compromise confidentiality—we don't think there is, but if there were—section 8 of the Mental Health Act I believe would supersede that. I would in the seconds I have provide you with at least that assurance.

Mr Patten: Thank you for your presentation. In the interests of time, we heard just prior to you from the Canadian Drug Manufacturers Association extolling the virtues of generic drugs. One of the comments you made was that many patients do not do as well with the generic drugs as they do with brand names. Is that based on research evidence, empirical observation or—

Ms Lowe: It's based on experiences of the clients we hear from, as well as the experiences we've heard from the other branches across Ontario through the Canadian Mental Health Association. The best comment I could make to that would be that we believe our clients when they tell us they're just not as good all the time.

Ms Lankin: My question's about Jane and Joe. Jane's learned some new skills at the urging of the Minister of Community and Social Services—how to barter with her

grocer for the cost of a tin of tuna—and now the Minister of Health wants both Jane and Joe to go out and barter with their pharmacists and find the best price; particularly Joe, who perhaps doesn't have the experience of bartering because his food's provided for. How he's going to deal with going from pharmacy to pharmacy to pharmacy to get the best price on those seven different prescriptions that you talked about?

Mr Parsons: Poor Joe has everything delivered to him. He would get it through the boarding home itself. There would be additional drugs that he might get that wouldn't be psychiatric, but most drugs would be dealt with by the boarding homes. So he quite often doesn't get out. That's the issue; he doesn't leave at all.

1530

Ms Lankin: He doesn't have to bargain for them.

Mr Parsons: No, he would—

The Chair: Thank you for your presentation. We appreciate your interest in our committee process.

Mr Carne: If I could just add one thing to respond to your question. In the Mental Health Act, when information is released to non-doctors, the name is blanked out of all information, so when you're doing this maybe that could be blanked out and some sort of code number used for confidentiality.

Mr Clement: That's right, and that's how it's going to be.

Mrs Ecker: It supersedes Bill 26.

Mr Clement: That trumps anything that we're doing. The Mental Health Act says it.

ONTARIO ASSOCIATION OF NEPHROLOGISTS OMA SECTION ON NEPHROLOGY

The Chair: The next group are the Ontario Association of Nephrologists, Dr Gerald Posen and Dr Peter Blake. Good afternoon, gentlemen. Welcome to our committee.

Dr Gerald Posen: Thank you very much. We welcome this opportunity to appear before the committee to address certain issues relating to the bill and to the provision of health care in Ontario.

First of all, I'd better tell you what nephrologists are. It will help all of us as we approach this. We are the physicians who look after the patients on haemodialysis, peritoneal dialysis and kidney transplant in the province. A major portion of our work involves just that. Both dialysis and transplant—and this is really important to understand—are life-sustaining therapies; prior to the 1960s patients with end-stage renal failure all died.

Our members work in hospitals where most of the dialysis services are currently provided. Due to the special nature of our work, 80% of the nephrologists in the province hold privileges with the various teaching hospitals throughout Ontario.

We would like to state that we acknowledge and support the government's efforts to contain costs and to control the provincial deficit. We are sympathetic to a government that is fiscally responsible and is willing to take active measures to balance the provincial budget. We also appreciate the government's need to make cuts

affecting all Ontario residents and industries, including health care.

We would like to make a few comments on aspects of the bill which affect, firstly, all physicians in general and, secondly, raise concerns about nephrologists.

It is not our intention to comment on all the statutory amendments contained in the bill. Our purpose is to sensitize the committee to the needs. Our long-term objective—and this is something we have talked about and we are trying to relate with the government—is to foster a working relationship with the government and the Ministry of Health to preserve and enhance the delivery of quality health care to the people of Ontario. We ask you to consider our comments in that light.

As members of the Ontario Medical Association Section on Nephrology, we support—in fact, we enthusiastically support—the idea of a partnership. We have been active in the very early days of this when the Ontario government was unbelievably supportive in starting dialysis facilities and home dialysis in the province. Probably none of you here realize it, but Ontario was probably the first government in the world to start a home dialysis program fully funded by the ministry, and that was in 1968, and that was through meetings with our early association and the Minister of Health. So we have a long history to build on.

We feel it is terribly important that the ministry continue working with physicians through the Ontario Medical Association to help each other. It is our recommendation that the ministry resume negotiations with the OMA in an atmosphere of mutual cooperation.

The amendments to the Public Hospitals Act give the hospital board the power to refuse applications for appointments, reappointments or to make changes in hospital privileges, revoke appointments and cancel or substantially alter hospital privileges if the hospital board or the ministry decides the hospital should cease to operate. Amendments leave it open that such changes will also apply to situations other than hospital closures, and this is one of our great fears. It appears that no hearing would be required and that the statutory safeguards that would otherwise protect the physician's rights would not apply. The hospital and the ministry would be immune from liability. This is very frightening if hospitals merge. Where do we have to turn to? As mentioned before, most of us nephrologists work in hospitals.

Given that all our members require their hospital privileges to carry on their practices, we are deeply concerned with these amendments. The existing balance of power in Ontario's hospitals, between the administrators who by their nature are focused on issues of cost containment and physicians who are the patients' advocates, has served the interests of Ontario's patients very well. It is the permanence of the physician's appointment that allows him to challenge the hospital administration in order to ensure the highest quality of care.

The bill opens the door to allow financial and other improper pressures to be brought to bear on physicians to influence their clinical judgement. Only the best interests of the patients should in fact influence a physician's judgement.

The bill, we would state, we'd like to be amended to provide that the only time physician privileges may be revoked, outside the already well established situations contemplated by the Publics Hospital Act and case law, is when a hospital is closing, such revocation to take place upon the date of closure. The right to revoke privileges should not apply when hospitals merge or in any other situation. We cannot overemphasize the importance of this to the interests of our patients.

We agree in principle to the privacy act and we support all that has been said about this. This is terribly important for all of us.

Now I'd like to turn to issues affecting nephrologists and turn it over to the chair of our association, Dr Peter Blake.

Dr Peter Blake: Thank you, Gerry. I'd like to talk a little bit here about the issues that affect nephrologists and nephrology patients and are related to this bill.

Let me, first of all, give you a little bit of background. In Ontario, over the last decade, there has been a steady increase in the need for dialysis. If you could perhaps turn to the first exhibit, you'll see a graph which I think shows this fairly clearly. Over the last decade, from about 1,500 patients on chronic dialysis therapy, we have gone to a stage where we have now almost 4,000. That's a very, very emphatic increase that's going on, and this is the background against which I'd like you to see these comments.

The increase is occurring. Why? Well, primarily, there are two factors here. Firstly, medicine has just gotten a bit better at doing dialysis and keeping people alive who would not have been able to even receive dialysis 20 or 30 years ago. For example, an elderly diabetic, or not even an elderly one, say a 65-year-old diabetic, would not have been accepted for dialysis in Ontario or in most countries 20 years ago. Now that's almost routine, and those people are living fruitful lives. So the number of people we're able to dialyse has increased at quite a rate.

A second phenomenon that you're all aware of is the aging of the population. Like many diseases, this disease mainly affects older people.

So these two processes working together have led to this enormous increase in the number of patients whom we're having to deal with, and it looks like it's going to go on for some time yet. There's no sign of a plateau being reached, either in this or in other western countries.

It's important to emphasize that this increase is a real and legitimate increase. This is not something that physicians have drummed up to make more money for themselves or something. This is a patient-driven or a disease-driven increase in demand, and not a physician-driven—we're hearing a lot lately about physicians driving increased demand. This is certainly not a situation like that. It's a life-sustaining treatment and it's quite a straightforward matter; either the treatment is given to the patient or the patient dies. It's as stark as that.

As an example of the seriousness of this issue, in the United States where most things are done by paying for it, in health care this condition is treated differently to everything else. Since 1973 all US citizens, regardless of age or income, have the right to receive dialysis and renal transplant free of charge. That's a very unique thing in

the United States, and it strengthens the point that I'm making here today.

For these reasons, I think it's inappropriate for the government to try and resolve the present utilization problem, or perceived utilization problem, by imposing restrictions on the medical profession as a whole, regardless of specialty, in the manner that's being proposed in this Bill 26. It's a little bit oversimplified to assume that utilization can be controlled by restricting the ability of physicians to bill OHIP and by second-guessing their professional judgement. As this example of dialysis demonstrates, there are legitimate areas where utilization is increasing in a manner that's quite outside the control of physicians, and it's very important that this be recognized and facilitated, as it has been in the past.

1540

The second point I would like to make is, the government has recently announced—and the government is aware of this dialysis issue; both this and the previous government—its commitment to provide additional funding for dialysis in the province. We very much welcome these initiatives, for the reasons I've shown you; there's a proven need for this service.

Having said that, we're concerned that there hasn't been a corresponding increase in funding for the doctors who are going to ultimately be responsible for providing these services. In other words, the government has provided additional funding for dialysis, all of which will be given to hospitals and health care facilities; it hasn't worked out clearly who's going to deliver those. We have, as I'll show you in a moment, a limited number of nephrologists in the province. Unless funding is made available, there won't be enough nephrologists to deliver the sort of quality of care we think we're delivering now.

We agree that it's appropriate for the government to commit additional resources, of course, and to issue new licences for dialysis services. But if we don't fund appropriate numbers of physicians at the same time, and if all the money to pay for this comes from the present fixed OHIP billing globe, we're going to find that not just the nephrologists are unhappy about that but the rest of the physicians. We've become very unpopular, you might understand, with our fellow physicians because we can't decrease our utilization. We're being asked by the OMA to claw back, to decrease utilization; we find we can't do it, not because we're nasty but because it's disease-driven. You can appreciate that we're finding that we're having to take on an ever-increasing workload without additional funding, and this is a quality-of-care issue ultimately. You can only look after so many patients and do it well.

Let me move a little bit into the area of manpower for my third point. With respect to the government's powers in this bill to direct where physicians may work, what services they may provide and how much they may bill, it should be recognized that in many specialties—and I'm going to talk about nephrology. There's currently a marked shortage in many areas of the province of nephrologists.

If I could take you to the second exhibit, it's not the most easily readable, but it compares all the provinces. If you look opposite Ontario and halfway down, you'll see

we've expressed this as the number of dialysis patients per nephrologist in Ontario. In 1986, a mere 10 years ago, there were almost 25 dialysis patients for each nephrologist. That number has gone up now to almost 38 in 1993. That's a 50% increase in the workload per nephrologist. That's resulting from the fact that the number of patients is increasing much faster than the number of nephrologists.

Why are the nephrologists not increasing? Well, it's not been, up to now, an attractive specialty for medical graduates to do. It's perceived as having a high workload that keeps increasing. It's an on-call specialty; it's one of those ones where you get called at weekends and at night-time. The patients are ill, and they're chronically ill, which some people don't like to deal with. Also, it tends to be tied in to university centres because of the nature of where this therapy is delivered, and that limits people's mobility somewhat. So it hasn't been the most attractive one, and up to recently a significant proportion of Ontario's nephrologists have been foreign medical graduates. That is becoming less feasible now, so we're going to have to generate our own nephrologists. But it is not something that has been terribly attractive up to now.

The third exhibit makes an interesting point about this. We have an age distribution problem. If you look at exhibit C, it tells you which five years of their career each nephrologist in Ontario is in. You'll notice a big peak in the 55-60 age group. This reflects the fact that nephrology is about 30 years old. The first generation of nephrologists is reaching retirement age. This is going to further accentuate the manpower problem unless we get better at getting people to do this particular specialty.

Despite all these difficulties, we feel that we've worked hard as a group to try to address problems in the province with nephrology. We had an issue a few years ago, and we still do, with the northern areas, that it's difficult to get nephrologists to go and work, just like other doctors, in parts of northern Ontario. That's improved a bit; we still need to do better. We believe we can address this without having to force people to do things. We have a number of ideas that we'd be happy to share with the Ministry of Health. Obviously, some include incentives, but there are other methods that could be used as well. Certainly, forcing people to do it would not be something that would be very attractive to us, and you've heard that from many other speakers.

I think also, to the extent that Bill 26 is viewed as detrimental to physicians in general and the practice of nephrology in particular, it will make our shortage problems worse and further compromise patient care. We believe we can avoid these things. We would like to talk to the ministry and help solve the problem. We have a tradition of doing that and we think we can continue to do it effectively.

Moving on to the next point, Bill 26 gives the Ministry of Health the authority to increase or decrease the fees payable to physicians according to a lot of different factors, including specialization, experience, frequency of providing the service, the place and the setting. It even gives the authority for paying nil for some services. We feel these are very extreme powers.

If this bill is passed, the minister will have the authority to determine who is an eligible physician, who will be allowed to bill OHIP. He will have the exclusive authority to define what services are insured and under what conditions and limitations they're insured. These issues will no longer require prior consultation with and approval from the OMA. We regret this.

Based on our experience with proposed fee code adjustments to the OHIP schedule, we feel it's important for the government to recognize the sorts of factors that I've been talking about when decreasing or eliminating fees for various services. A decision to decrease the fee for certain prescribed services may have an effect on the availability of those services, and in something like dialysis that's obviously very important because it's life-sustaining.

We would urge the minister therefore to amend Bill 26 to leave the fee codes under the purview of the OMA. If he won't do that, we would invite him to consult with the nephrologists on issues pertaining to our fee codes so that changes that are made are made in a way that will not compromise patient care.

The fifth point is one I briefly want to deal with: the Independent Health Facilities Act. This present ministry has introduced a new initiative in dialysis which we welcome. They have opened the field up to independent health facilities. Previously, dialysis has been overwhelmingly delivered by hospitals. Therefore, the Independent Health Facilities Act suddenly becomes an issue of some concern to us.

We would very strongly favour that this process that has gone on just in the last six months for dialysis, which is a tendering process, the so-called RFP or request-for-proposal process—it's an open tendering or bidding process—continue if this is the way we're going to go. We don't like the idea that the minister would have the ability to request proposals from one group only, as he saw fit. We feel that's an arbitrary power. We like the idea of this process being as public and transparent as is possible.

With respect to the minister's powers to revoke a licence from an IHF, an independent health facility, for cost-containment reasons, we'd also like, in the interests of fairness, that there be some appeal involved in these cases, that this relatively arbitrary power be subject to appeal. And I think fairness dictates that individuals who are operating dialysis facilities in the future in Ontario should be compensated for their investments if they are rendered useless as a result of a minister's action.

In the spirit of co-operation, our organization would be willing to work with ministry officials and the College of Physicians and Surgeons of Ontario to expand quality assurance guidelines. This is now an important issue as well. If for the first time we're going to have private companies delivering dialysis in Ontario as a new initiative, we think it becomes increasingly important to ensure that quality is maintained. We pride ourselves in Canada generally that we have a very high standard in our dialysis units. We sometimes compare very favourably with the US and we like to be quite proud about that. We're concerned that with the independent health facilities coming in, the standards could be allowed to drop if

we don't monitor them very carefully. We would like the minister to get involved in ensuring that standards are maintained when this goes ahead.

I'm going to finish up by saying we would like to acknowledge again the initiative of the Ministry of Health in this recent request for tendering. I think it indicates that they are aware of the dialysis problem, that it's a sincere attempt to solve it. We think some of the aspects of Bill 26 threaten this process and make it less likely to be successful.

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We'd like to go on cooperating with the ministry. Some of the statements made lately about doctors haven't been that nice. We think, by and large, we're a reasonably dedicated group of professionals. Most of my nephrology colleagues work hard. Most of them work, I think, 50 hours or more a week. Maybe politicians find that relatively little. Over the course of each day, we deal with high-pressure medicine. We feel we're pretty dedicated and we feel we'd like to be involved in decision-making about our patients. We feel we know best, I suppose, about a lot of the issues pertaining to those patients, and we worry about a minister or a ministry having arbitrary powers to overrule us.

If I could sum up, we have ever-increasing numbers of patients. We don't have enough nephrologists. This is a concern. It's a simple supply-demand problem. We're worried this imbalance will get worse and we feel we have something to contribute to prevent it getting worse. It's a basic quality-of-care issue for our patients and we'd like your support on this.

The Chair: We've got about three minutes per party left for questions, beginning with the Liberals.

Mr McGuinty: Thank you very much, gentlemen, for your presentation. I think one of the questions we have to ask ourselves any time we have a piece of legislation is: What is the policy that informs it, what is the government trying to do, and in particular, I guess, with respect to the health care aspects of this, what role does the government see doctors playing in the province?

I'm reminded of what a professor told me once, somewhat in jest, about universities. He said, "They'd be great places but for the students." It seems to me the government is saying, "The delivery of health care in the province would be great but for doctors."

I'm very concerned in particular about new blood, introducing new blood, getting new doctors on line. I think it's tragic if we can't create a climate which encourages young people both to get into medicine in this province and, furthermore, to stay here and practise. What has to be done in order to ensure that happens?

Dr Posen: It's very difficult to answer that. What I see in medical students today is the same dedication that I've always seen in students.

I think people are afraid of an autocracy. What we have done in the past with governments way back—again, I was part of the original group with Matthew Dymond, when he was Minister of Health, that got this home dialysis program, the first in the world, the best in the world, here in Ontario. It was meetings with him, meetings with the ministry, and this is what we're asking for. Let us continue to meet and discuss together, and I

think people will stay in the province. We all understand times are tough fiscally. We're not asking you anything financially. We're asking to be able to talk to you.

Dr Blake: I would add one thing to that. I see the problem not just as people not wanting to do medicine; people still want to do medicine. I would like to see them wanting to do specialties like nephrology. Obviously, I've got a bias here. I think we've got to make it attractive to do things like that. Encumbering us with the sort of autocratic things Dr Posen has talked about might make that more difficult. There's a perception that: "I don't want to work in a specialty. You spend all your time fighting for this and fighting for that. I'd rather be out on my own, working somewhere else." I wouldn't like to encourage that attitude further.

Ms Lankin: I want to particularly ask you about your concerns around revocation of hospital privileges. It's pretty clear in the act, under a closure situation, what the powers are of the hospital CEO and the fact that there's no appeal from it. I would think the argument that the government would put forward is, "But we've allowed for other regulations to control situations other than closures, so therefore you should trust us that we're going to do something different." It doesn't say that the existing process, with all of the due process and appeals, will prevail, but something that's going to be written in regulation.

As Dr Shaver said earlier, you've got to wonder what those regulations are going to be. There won't be public scrutiny of them, there won't be legislative debate; they're done by cabinet. Whether it's with respect to that, whether it's with respect to the assurances we get that they're not going to violate the Canada Health Act although they're moving things out from under the protection of the Canada Health Act clauses and pieces of the legislation, or the assurances that the hospital restructuring committee is going to listen to DHCs although it doesn't say that in the legislation, everything's going to be done by regulation. Someone said to us yesterday, "It's like the government's asking us for a blank cheque, but we don't know what the number is they're going to write in."

Could you tell us what you would like to see with respect to issues of revocation of hospital privileges? Do you want it spelled out in the legislation? Do you want an assurance that it's the same as it is now except for closures? What changes are you asking for?

Dr Blake: Yes, I think exactly what you say. We're reluctant as a group to take this sort of thing on trust.

Let me give you an example of what it's like for a nephrologist. We're sometimes troublemakers in a hospital. As I've said before, we can't control our own utilization. We annoy the administration. We fight with them at times, in a healthy way. Most of the time we get on okay but we do fight with them because they've got a shrinking pie and we want more of it. We're not always that popular. The fact that they can't arbitrarily sack me or my colleagues makes it easier for us to do that.

I would worry about a situation where my job could be unilaterally revoked because I might be a little bit of a troublemaker. You might say that's not going to happen and it's unrealistic, but I don't know; maybe it will. I

don't like taking that sort of thing on trust. I want to be able to be a patient advocate, and that really does happen; it's not a theoretical thing. Every week in every hospital, I think, and Gerry will agree with me, I'm sure, we're in a healthy sort of battle with the administration to make sure our dialysis patients get what we think they need.

Dr Posen: If I can just add to that to say that now there is merging talk. Dr Blake comes from London, Ontario, and they're merging in London. We're talking merging in Ottawa. We want to go ahead with it. I cannot emphasize to you more how much we all are aware of the financial problems. We're not trying to hide from them. But if hospitals merge, we don't want an administration that I fought with last week to turn around to me and say, "Okay, Posen, sorry, you made too many bad points." This has to be carefully spelled out, and it can be in your legislation.

Mr Rollins: Thanks for you two gentlemen being here. It's much appreciated to get up to speed on some of your thinking on some of this.

I think this government has at no time ever thought that the quality and the care and the utmost of the whole health system—it has got to be in cooperation with the doctors. I know that for some of the moneys we have taken from different parts of the health budget and put back in, it's certainly been one of the areas where we put it back in, dialysis, and we've certainly put some of it back into areas that aren't connected with hospitals, in the assumption that probably down the road some of those areas are going to be without hospital services.

We can provide to the communities of Ontario, whether it's in northern Ontario or 60 miles away—I come from Belleville, and just recently, in the last few years, we finally got a dialysis system in Belleville. All those patients were driving from Belleville to Kingston and/or to Oshawa or to Peterborough. I think that's the kind of thing that this government has backed up with spending money out in the community to allow our patients to a little bit closer facilitate those services.

There's no question about it: Under the act at the present time, even though there is an independent opening up of some biddings of natures, those conditions will have to be held at the utmost of quality and care, because under the regulations we've got to obtain that, and we'll have to rely once again back on the doctors to make sure this quality of care is continued. I think we need to cooperate with you people, to talk to more of your people who are going in to be doctors to take up your segment of the doctor profession, because we need, as you tell us, more of those people as our aging population goes up.

Dr Posen: I agree with you and I think all governments—the Liberal, the NDP and the present Conservative government—have worked very closely with us.

This bill scares us, basically. We need some assurance that the cooperation will go back to what it was in the past, and if what you say is true and this does come out, if the bill is changed so that the cooperation is part, that it's not a fight between the OMA or it's not a fight between the doctors and the government—let us go back to what it was before. We're a partnership. We need each other.

The Chair: Thank you, doctors. We appreciate your interest in our process and your presentation.

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LINDA KEMP

The Chair: The next group—it's not a group; it's one lady, Linda Kemp, a registered nurse. Good afternoon and welcome to our committee.

Mrs Linda Kemp: Honourable Chairman, distinguished members of the committee, I would like to thank you for your consideration in providing the opportunity to voice my concerns on a number of the health care issues which would arise from Bill 26.

I am a neonatal ICU nurse with a considerable background of experience in medical research. I'm a member of the reproductive panel. However, the concerns that I present today may not be representative of the reproductive panel or of the Ottawa-Carleton district health council. I am present as a nurse and as a concerned citizen.

The following Bill 26 concerns will be addressed:

The power given to the Health minister to close or merge hospitals or to take over their operation and to dictate type and volume of service without proper consultation.

The deep cuts in care leave gaps allowing for a loss of accountability. Moreover, in protecting itself from legal liability resulting from the restructuring process, the government eliminates any recourse currently available to the patient. In other words, responsibility or culpability for patient outcome on the part of the physician, the institution or the government falls into a void.

The impact that these cuts and changes already have and will have on the quality of care with specific examples of risks and complications to patients, gaps in service and insurance coverage, the rapid incorporation of unproven technology into medical use, the hidden costs, and the effect on mother and infant safety with early maternity discharge.

The ludicrous and incomprehensible assumption that the government, without the benefit of medical training, patient examination or history, can decide for doctors regarding medically necessary procedures, consultations and treatment; in short, patient management. Why have doctors?

The introduction of United States-style, cost-driven managed care into our system (1) with the ability of the Health minister to decide which companies can provide care without submitting to a tendering process and (2) in the deletion of the requirement to encourage Canadian-owned, non-profit health care clinics.

Finally, the removal of price controls on many drugs, freeing the drug manufacturers to charge whatever the market will bear, especially in light of large insurance carriers screening and excluding patients.

Hospitals have reduced inpatient services in many areas due to financial pressures. New technology and methods of treatment such as laparoscopic surgery have been incorporated rapidly into practice in response to the crisis. However, laparoscopy does have the potential of causing a multitude of complications, as there are risks

inherent in the procedure itself such as possible perforation of internal organs or blood vessels through the insertion of the Veress needle or trocars, haemorrhage, ureter and bile duct injuries, metal allergy, gas embolism and possible spread of cancer. These complications, which can range from minor to major to even fatal, can or will create additional demands on the system.

Dr Marco Pelosi, in a recent issue of *Obstetrics and Gynecology*, noted "that it is unfortunate that the type of technique, as complicated or risky as it might be, is not considered a crucial issue as long as the current criteria of acceptance of laparoscopic surgery over laparotomy—shorter hospital stay and faster recovery—are fulfilled."

Complications can result from the inadequacy of the limited, two-dimensional view, equipment malfunction and failure, surgical inexperience, and especially from an incomplete evaluation of outcome.

Dr Ronald Schwartz, with the department of gynaecology, Medical College of Georgia, notes that "the true incidence of complication is unknown due to a lack of case studies and the fact that investigators are reluctant to report complications because of fear of injury to personal reputation or medico-legal complications."

Dr Victor Gomel, author and professor of obstetrics and gynaecology at the University of British Columbia, makes a very important distinction about laparoscopic surgery in noting that "operative laparoscopy has been termed 'minimally invasive surgery'" and states that surgery "is equally invasive regardless of the approach. A more realistic term is 'minimal access surgery,' as only the route is minimized." He further cautions that the term "'minimally invasive' also creates the impression that the operation is minor."

The 1995 Auditor General's report has identified a significant gap in pre-market assessment and risk-rating of medical devices. Devices not listed on the regulation as being high risk do not require pre-market approval. Unfortunately, few changes have been made to this list since 1985, with the result that many new devices viewed by the bureau as being high risk are not subject to pre-market approval, due to delays encountered in passing the amendments to the regulations proposed by the health protection branch. As it stands now, action regarding a device can only be taken after it is marketed. The Hearn report noted in 1992 that approximately 5% of medical devices undergo in-depth, pre-market review and that the safety of medical devices was the biggest problem area being reported by 44% of institutions.

The true incidence of complications is not yet known in many instances due to under-reporting. It is difficult to report complications if there is insufficient data on outcome. This determination of outcome is only possible with the establishment of an accurate complication rate based on long-term follow-up of possibly two to five years. Telephone contact at regular intervals could provide valuable information and early identification of patient problems. Outcome could be further determined by an evaluation of efficacy and cost-effectiveness based on the rate of complications and factoring in the hidden costs of additional treatment and readmission, costs of the expensive equipment and increased OR time, as well as a comparison with other methods of treatment and

identification of the appropriate indications and risk-benefit ratio to the patient.

The present situation is that new technology and treatment are being very heavily relied upon and promoted in response to the current cost constraints in medical care. A restructuring of the system is evolving while a need for critical evaluation still exists in terms of safety, outcome, efficacy and cost-effectiveness. If the evaluation process of this in itself is incomplete, how can we evaluate the impact of these changes on our health care?

The Ottawa Citizen cited a recent example with the contamination of laparoscopic insufflator pumps with patient fluids, thereby creating a hazard of cross-infection. This is a shocking, potentially life-threatening and totally unacceptable situation. What is also inexcusable is that the public was never properly notified. With all of the concerns about the blood supply, blood products and awareness of HIV and hepatitis, the seriousness of this cannot be minimized in any way. As hospitals actively promote laparoscopic surgery to the public, and as the method is rapidly incorporated into use, I think some explanations are in order.

The problem regarding medical devices could be addressed by increasing the mandate of the medical devices evaluation division in monitoring advances in technology and their safe application in health care as a priority.

The need for an independent health auditor similar to the US Surgeon General with the ability to override the system when necessary and provide warnings in special instances was recently proposed by Dr Richard Mathias, the federal government's director of field epidemiology, to the Krever inquiry.

Research-based health care is necessary to ensure safety and maintenance and improvement in the quality of service.

The end result? Patients are being discharged home rapidly, often in a much earlier stage of recovery, with increased needs for care and without the benefit of time in hospital to allow for greater recovery, identification of problems and complications, counselling and treatment. Many serious post-operative complications can occur after 48 hours, and for many patients this may be long after discharge. Coupled with the present inadequacies in community and home care, where and how can we expect all of this to take place? In a sense, are we not discharging patients out the front door only to return through the back door?

What do you do if you experience complications after hospitalization? Do you seek out your family doctor, who has probably not yet received your discharge summary from the hospital? Do you go, if you are able, to a community health centre or urgent care centre, where they may not have any of your records unless you are already their patient?

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Do you use the emergency services at the hospital you were discharged from, creating an additional burden on that service?

Will you have access to the outpatient clinics? The Ottawa-Carleton Regional District Health Council report

projects that there will be no increased demand on this service due to a further shift of care to community and home care.

If you do not meet the specific criteria for home care and VON services at the time of discharge, will it be possible to seek their assistance?

Are there hidden costs to the patient as the transition to community and home care takes place?

No matter which of these routes you choose, there is a chance that vital information about your health will not be properly reported to your surgeon or other specialist. How will they make accurate judgements about the effectiveness of this treatment if this information is lost to them? The danger is that this determination will be made on the patient's condition at the time of discharge or shortly thereafter, not on the fact that they may have required further treatment, hospitalization or surgery. Even worse, patients may try to deal with problems or complications without seeking assistance.

One of the most underrated benefits of a longer hospital stay in any situation of illness, surgery or childbirth is that a period of rest and recovery was imposed upon us for our own good. In the past the temptation to do too much too soon was eliminated. Now it will be encouraged.

As the care shifts from hospital to community, closer links must be established. CLSCs in Quebec offering combined social and medical services can serve as a model.

Significant gaps in care are already evident:

Premature discharge can leave the patient very much at risk in the home situation.

Ambulance service is inadequate in many outlying areas, areas that may also be seeing hospitals closing. In addition, requirements for ambulance to take the patient to the closest facility may not always be in the best interests of the patient.

There is a catch to VON and home care and there are hidden costs. Patients are required to have a medically necessary procedure in order to qualify for VON care. In order to be eligible for home care, you must first be eligible for VON care. If you don't qualify for VON care but definitely require home care, you may be required to pay for some services.

There are hidden costs to the patient.

I'd like to bring to your attention a major concern with private insurance carriers.

At the time of my recent discharge from hospital, my husband was in transition in employment. As a result, we were faced with a three-month waiting period for eligibility into the new employer's plan. In order to bridge the gap, we applied to Blue Cross, now Liberty Mutual. As a result of their review of my current health history, I was denied preferred hospital benefit and prescription drug benefit.

In addition, our three children, who all have asthma and allergies, not an uncommon problem, were all denied coverage for all asthma and allergy medications.

The appalling fact is that if I had not been so fortunate in having a new employer-based medical insurance plan, I would now be without extended medical coverage and therefore also without medication coverage. Our children

would be without coverage for all asthma and allergy medication and we would be financially devastated.

So as you are delisting services and slashing your way through the health care system and allowing drug manufacturers to charge whatever the market will bear, keep in mind that the private insurance carriers will be carefully screening and excluding people and will not be there to cover the consequences for the patient.

Who will pay for what the government might classify as inappropriate use of resources? The patient? The doctor? OHIP? Not likely. Private insurance carriers? Not a chance. So much for universal health care.

Proposed changes to local health care raise other troubling questions:

Waits for surgery may be decreased for some, but will this result in longer waits for others requiring hospitalization as fewer beds are available?

We have already experienced cutbacks in beds. Has there been a corresponding decrease in management since there are fewer beds to manage?

Are expectations about the coping abilities of patients and families too high? Feelings of isolation and helplessness and insecurity can result from the rapid transition in care. This will certainly add to the stress of dealing with illness and incapacity. Basic support of the patient is in itself therapeutic.

Will you be separated from your newborn if either one of you requires rehospitalization? The maternity and early discharge program is already suffering the effects of cutbacks. The incidence of newborns readmitted for problems such as jaundice and dehydration has doubled between 1987 and 1994 as the hospital stay has been reduced to 2.7 days. Noting that engorgement and dehydration are occurring sooner, Dr Jack Newman of the breast feeding clinic at Toronto's Sick Children's Hospital commented: "In my opinion, early discharge is a disaster, although the government would never admit it. There's probably not a lot of money being saved because it costs \$1,000 a day to later readmit a baby to ICU."

Not only are the insurance companies controlling health care in the United States, they are driving the system into unsafe practices here in Canada.

In a recent Medical Post article, Dr. Mennuti of the American College of Obstetricians and Gynecologists stated: "The motive is cost-containment and obstetrics is, not surprisingly, a target because obstetrical delivery is the most frequent cause of hospitalization in the United States. However, the safety of early discharge has not yet been studied adequately or established.... Not all serious maternal or newborn problems are evident in the first 12-24 hours."

I recently contacted the American Nurses' Association and obtained this information. A tremendous backlash is developing in the United States against managed, cost-driven care. Many providers are now in the position where they no longer have any say. They must discharge patients in less than 48 hours whether or not it is appropriate. If they fail to comply, the provider risks exclusion from the system.

The states are reacting quickly to ensure 48-hour care. In total now, 20 states, almost half, have introduced or passed 48-hour maternity care legislation, with 96 hours

for C-sections, as well as individual hospitals and cities taking action to ensure the same. This is being fought with legislation on a federal level as well with the Newborn and Mother's Protection Act of 1995.

With proposals here to further reduce the stay to 24 hours when possible, we can expect the situation to worsen and place even greater demands on an already compromised community and home care situation.

At this point, I would also like to comment on another obstetrical issue which has a number of safety concerns. Independent birthing centres were recently raised as a possibility for Ottawa-Carleton. The reproductive panel has stated clearly its concerns, which included a lack of anaesthesia services and a lack of emergency medical and surgical backup services leading to a potential lack of safety. It was stated that the birthing centre concept should be physically attached to an acute care facility. I would like to confirm the ministry's decision not to proceed with funding to free-standing birthing centres and to focus resources on existing facilities.

The health council reports have acknowledged these complications:

The number of beds cannot be reduced without putting in place alternative services.

A serious inadequacy in home care services must be addressed. There is a need for reallocation for the expansion of the home care support program to support shorter stays.

Many of the agencies offering long-term and in-home care receive all or most of their funding from the Ministry of Health.

In the last year alone, referrals to home care have increased 10%.

Remember, the home care program in Ottawa-Carleton is \$800,000 over budget this year without the province yet making up the loss. The immediate consequence is that home care is now in the process of reducing services, and VON services have been decreased by 15% recently.

As the Ministry of Health provides all or most of the funding for long-term and in-home care, we can look to your management of this as a microcosm of what we can expect if you were to manage our health care. You have removed \$33 million in long-term community care funding, and while encouraging shorter hospital stays for maternity care, medical treatment and promotion of unproven technology, further inadequately fund the transfer of care to the community and home care situation, and then conveniently eliminate culpability for outcome or backlash through dictatorial legislation. This is unconscionable.

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There are serious gaps in service which, without relief, will only continue to widen. Action is needed now to ensure that this situation is remedied. Reallocation of funding is the priority. A coordinated continuum of care must be in place and available to the patient before further cuts and shifts in care occur, and it is imperative that the new technologies, the changes in medical and surgical treatments and in service delivery are monitored and evaluated closely as these are the basis for the foundation of change that is occurring.

I would like to close with the following two quotes:

Dr Shindul-Rothschild, assistant professor, Boston College, school of nursing: "When the health care system itself becomes the primary threat to quality care, advocacy by necessity must move from the bedside into the public sector. No one knew this better than the founder of modern nursing, Florence Nightingale."

And from Florence Nightingale: "The ultimate goal is to manage quality. But you cannot manage it until you have a way to measure it, and you cannot measure it until you are able to monitor it."

In closing, I would like to express my sincere appreciation for the opportunity to be present today. It is at once a challenge and an honour to participate in formulating change in this manner. I am hoping that many of your questions will be answered with the rather considerable amount of documentation I have provided. I have tremendous faith in the system and believe that the task can be accomplished while maintaining the priorities considered universal.

Ms Lankin: Thank you very much, Ms Kemp. I appreciate your presentation. It was very thorough and I think provided a very interesting perspective on some of the challenges we all face in engaging in health care reform and restructuring. I thank you for the documentation which we'll have a chance to go through.

As a former Health minister, all of the pitfalls that you were describing—I remember trying to grapple with understanding the complexity of the restructuring challenge before us and wanting to avoid those pitfalls and wanting to ensure that the process was community-driven, with an open opportunity for a consensus to be developed, because I'm worried, quite frankly, that as you narrow the number of people you listen to and/or who make the decision, the greater chance for error. You've talked about that a lot in your presentation and you underscore it by also talking about the fact that reallocation is a priority.

On a number of occasions in these hearings, I have urged the government to make very clear that the minister's powers around hospital restructuring and the hospital restructuring commission are linked very clearly in the legislation, with terms of reference, mandates, limits on powers and linkages to district health council led processes. We've been assured by the government that's what it intends, but it's not what the legislation says.

Here's one of the reasons I believe that's really critical. I'll give you Windsor as an example, where they did not just a hospital restructuring, but as we know, you need to do a health system restructuring. They've identified moving from four hospitals to two and they've identified the service gaps in the community, and the need to take the operational savings from moving from four hospitals to two and how to reinvest it in the community for a seamless health system in that community. The commitment had been there from the previous government, in working through this process, for that to happen. This Minister of Health has said: "Yes, close your hospitals, but I'm taking the money. It's not going into the community."

Metro Toronto has just done an extensive report on hospital restructuring—not full health systems, but they

did identify some community gaps. They have a phased process of where you have to invest up front before you close a service and where you can reinvest after. They've timed it all out; no commitment that this would in fact happen.

You may not have time to answer, but perhaps in response to someone else. That reallocation is, I think, in jeopardy.

Mrs Johns: I'd like to thank you for your presentation. What your presentation reinforced for me was that we have to maintain quality assurances. They are mandatory. We have to know that our health care is high quality, the best in the world, as we all believe it is. I think all of the people around this table sit through these hearings because that's what they want to have happen. We want to have best quality care, so we are working towards that, if that's any consolation. Sometimes I think that gets lost in the system.

What we are trying to do here is make sure that the community has an ability to say what they believe is good-quality health care, because we believe that the people in the community are the only people who can tell us what they best need. Obviously, I am not telling you anything when I am saying to you that long-term care and home care, VON, has been increasing at a substantial rate, 13% per year throughout Ontario for the last two years and probably before that also. These are the two stats I know.

How can we manage long-term care without doing some of the hard things we are talking about doing in this bill, ie, restructuring the hospitals? How can we allow long-term care to grow? Can you give me some ideas about things that we may have overlooked in our ability to try and manage health care and have a continuum of health care in Ottawa?

Mrs Kemp: I think there needs to be a better sharing of knowledge. Certainly the communication in the transition from the hospital to the community sector can be improved in many ways. I think we have to do it gradually, we have to use a lot of the existing resources and we have to be able to use the people who are already trained and perhaps change them in position rather than letting people go. Another of my concerns is that a lot of highly trained people will be lost in the transition.

I'm most of all concerned about the information transfer that occurs from hospital to community. From personal experience I know that does take place, and that can have grave consequences for the patient. I think that has to be a real priority as well.

Mr Patten: Thank you for that very comprehensive set of statements. I'd like to ask you a process question, though, because I see you are on the panel of the district health council. I am asking this question because at the moment, without the authority that the minister himself or herself would have to intervene at points at which it is perceived that the public interest is not being served, we get such interventions from the Ministry of Health to the point of embarrassing the people in this particular community who have worked through, very hard and very diligently—I won't comment on the quality of work, but they have worked hard—and continue to be undercut time and time again.

When you look at this particular bill, does this give you faith that this is a solution to rectify in making decisions that will be in the best interest of health care and of the health care for our particular community?

Mrs Kemp: I'm answering as a nurse and a citizen, not as a member of the district health council, but no, it doesn't give me faith. The thing that concerns me most is the tremendous amount of input that has gone into all the recommendations that have been made. It has drawn on the expertise of a huge number of people in the community with an enormous amount of background, and I think that is to be highly valued in forming any change. I think we can do it but I think we have to make the most of all the resources we have.

Mrs McLeod: Would you also feel that in any final decisions about restructuring, the dollars saved, or at least a significant portion of the dollars saved, should remain in this region to be used for community care or other health care needs?

Mrs Kemp: I have to answer for myself, not for the district health council, but that has been the priority and it continues to be the priority. Community funding has to be in place and the continuum of care uninterrupted. Let's put the structures, the steps, into place and make the money available before we make any further cuts.

The Chair: Thank you very much. We appreciate your involvement in our process this afternoon.

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OTTAWA-CARLETON PHARMACISTS' ASSOCIATION

The Chair: The next presenter is the Ottawa-Carleton Pharmacists' Association, represented by Frank Tonon, the president; Rosemary Killeen, the past president; Barbara Ramsay, a member; and Norman Ferkin, a member. Good afternoon and welcome to our committee.

Mr Frank Tonon: Mr Chairman, committee members, honoured guests, ladies and gentlemen, a special thank you for allowing us to address you this afternoon. I guess someone always has to be last on the docket each day.

My name is Frank Tonon. I am a community pharmacist and president of the Ottawa-Carleton pharmacists. My colleagues are Rosemary Killeen, who is past president and also director of the eastern Ontario district of the Ontario Pharmacists' Association; Barbara Ramsay is our Ontario College of Pharmacists' representative for this area; and Norman Firkin is a community pharmacy owner, our parliamentarian and member of our local association.

Our Ottawa-Carleton association is a voluntary association of pharmacists and pharmacy students from many different walks of the profession. We intend to provide leadership to all our pharmacists at the local level by providing ongoing continuing education units and seminars for them, assuring quality control in the general practice of pharmacy in Ottawa and disseminating information and education to the public, ultimately working to improve the quality of care we can give our patients.

This role is becoming more important in the current environment of rapid and significant change in health

care. Community pharmacists play a very vital and integral role in delivering health care services to the people of Ontario every day. As drug therapy becomes more complex and health care services are moved into the community, we need a strong community pharmacy in every community.

We recognize the need for Ontario to get its financial house in order. Obviously, we support this as owners and taxpayers. We believe that today's complex public policy problems are best addressed, though, by inviting all players to offer their ideas, which you have very admirably done, and by having all the players work together in a effort to share experience and to share knowledge.

We want to offer you a few viable solutions, as our colleagues have from the Ontario Pharmacists' Association and other local associations, and as obviously many groups and individuals have and will do in the next few days. We believe our view may be a little bit unique because it comes from the street level, an everyday level. This gives us a valuable insight into the problems, day to day, that government's trying to address, and hopefully we'll be able to give you good advice and sound direction.

As I mentioned, my colleagues and I are street-level pharmacists. We represent over 300 pharmacists in Ottawa-Carleton and a couple of hundred pharmacies, actually. Every week we deal with thousands of prescriptions and countless requests for consultations on non-prescription medications. We help people to decide on how to treat their minor ailments and sometimes we even help them to decide whether they should go to the doctor or to emergency. That does happen every day, so we do play a vital and important health promotion and illness prevention role every day. We are truly on the front line, doing our best to make sure our patients get the drug therapy and health care they need to get well and to keep them in good health.

Health care is obviously one of the complex sectors in the economy. It's been studied and analysed from every angle but still remains very difficult to manage, especially manage effectively. It doesn't lend itself to simple solutions.

Past experience has shown that changes must be introduced with great care to avoid unacceptable and unforeseen consequences. This user fee concept is a good example. This will not reduce the so-called abuse of the system. User fees are profoundly inequitable in terms of access to essential health care on a day-to-day basis. However, debate about this concept serves many, many stakeholders very well by drawing attention away from very important and very real issues.

The emphasis on dollars, on money, on getting the fiscal house of Ontario in order could well turn out to be one of the best things that's ever happened in health care if government policymakers do the right things and all the players work together to achieve appropriate changes.

We are at the retail level every day and we know from our experiences that if you want to solve a problem, whether it's a financial problem, a staffing problem, regardless, you must understand the underlying causes and focus on the right thing. We are very concerned that many of the changes proposed in Bill 26 will have

unintentional and negative effects and will not solve the cost problems that they're intended to solve.

We are very concerned that there is too little focus on making sure medications are properly used. When properly managed, drug therapy is highly cost-effective. Drugs are used every day to replace surgery, to prevent debilitating illnesses, to restore people with serious chronic diseases to fully productive lives, to get people back to work the next day.

However, there's lots of evidence that therapeutic drugs are not used properly. We have information from Ontario, from other provinces, from the States, substantial information that shows widespread non-compliance and drug wastage and very costly adverse effects when medication misuse does arise.

There's no hiding that in the past 25 years drug expenditures have been one of the fastest-growing categories of health expenditures: 15% of total health expenditures, that's a big number. Billions of dollars are spent on drugs each year; in 1993, \$11 billion in Canada, \$300 a person. But billions of dollars are also spent on correcting the results of inappropriate drug use and non-compliance, people not taking their medication properly, resulting in more than \$3 billion in direct costs to health care nationally. So spending \$300 on medication is one thing, but correcting it with another \$100 in expenditures is another thing when people do not take their medication properly.

Various studies show that at least 10% of hospital admissions can be attributed to medication misuse and adverse drug reactions, many of which can be prevented. Overusing drugs in Ontario costs more than \$50 million a year. Not using your drugs properly happens about four out of 10 times. A Quebec study shows, for one example, that more than 30% of the elderly take sedatives. Is this necessary? Is this cost-effective?

Prescription drug expenditures, obviously, for the elderly in Ontario have been increasing rapidly also. From 1985-90, drug ingredient costs increased 130%; per capita drug expenditures increased 93%. Just in British Columbia, one study finds that 30% of the elderly are exposed to six or more medications at any one time. We see this every day in our practices. Whether the patients are at home, living with family or institutionalized, too many people are taking too many drugs.

Unfortunately, in addition, inappropriate drug use is not only confined to the elderly. In the population at large there's widespread misuse of certain drugs on a regular basis: antibiotics, sedatives, painkillers, antidepressants. Some are necessary, but I'm talking about misuse.

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What about wastage? Medicine cabinet cleanup campaigns or brown bag drug return campaigns always find tons of drugs accumulated, millions of doses accumulated, and that's just what's turned in. You can imagine what's at home. The British Columbia royal commission heard that up to 50% of dispensed drugs may only partially be used. I wonder if they're used effectively. Credible, cost-effective quality care is the right thing to focus on. Ineffective services and inappropriate drug use and wastage must cease. So let's try to do the right thing.

Lots and lots of attention is given to "drug use review" and "drug use management" at the broad level of public or private drug plans. This aspect of appropriate drug use is important, but it's only a part of the picture. The critically important idea of counselling individual patients and monitoring their drug use is not only neglected but it is harmed by the increasing pressure on the so-called professional fee and the increasingly competitive retail environment. Yet, a relatively small investment in this area on drug use management for the individual patient would yield savings.

I'd like to stress that this situation just didn't happen. It's been brewing for many decades. No one group is to blame for it. Many players, many people, many governments, many associations have unintentionally contributed to the problems. No one group or association can solve it alone, obviously. It'll take a combined effort and a combined contribution of all stakeholders to improve the situation. A one-sided effort will not be successful.

The overall challenge is, how do we begin improving drug therapy, releasing some of these savings and improving treatment outcomes for all the people in Ontario taking medications? As we said earlier, no one party acting alone can solve this problem, but your community pharmacist, the community pharmacist in Ontario, is the key player. This is due to our training, knowledge, expertise and to our uniquely accessible physical location on the main streets of Ontario and our unique day-to-day personal exposure to our patients.

No one else can provide the services that patients need in order to get the most out of their drug therapy. No one else has the trust and the confidence of patients to reinforce proper drug therapy every day. If every community pharmacy does not remain a viable and active part of our health care system, the quality of drug therapy is going to degenerate. We can't afford that, short-term or long-term.

Our value has been shown in lots of studies and includes direct cost saving, and even avoiding harm to the patient, which ultimately is more cost savings. Take a number—\$74, say, for each outpatient pharmacist intervention; \$111 saved for each pharmacist nursing home or institutional intervention; in the States, more than \$37 billion saved in five years by pharmacists just being involved in reviewing drug use for patients. How can we avoid harm? Well, one big number: more than 90% reduction in emergency and physician visits over a six-month period when high-risk asthmatics were followed and educated by pharmacists.

We know that the community pharmacist can make drug therapy most cost-effective and at the same time improve treatment outcomes. For years the profession has been encouraged to improve services to patients, most recently by introducing the total pharmaceutical care concept. However, this is one concept, and patient care has just started to improve. This is because the key players, pharmacists, have not had the ongoing framework and practical tools they need in day-to-day life in the real world.

Many pharmacists have actively gone at it alone and created their own tricks—I shouldn't say "tricks"; their own niche maybe—created their own ways to help

counsel their patients, but the level of patient care must be upgraded on a wider and consistent scale if we're going to make a real dent in the problem of drug misuse and patient noncompliance.

We support the introduction of mandatory patient counselling by our licensing body, the Ontario College of Pharmacists. This at least establishes minimum patient contact every day. However, our experience at the street level indicates this is only one component of the process necessary to achieve rational, cost-effective drug therapy. The bottom line is this: If we are going to be successful, government and pharmacy must be partners, with other stakeholders, in devising the components of the process. We have to believe we can save money, but we have to do it together.

Some street-level pharmacists have developed, as I said, their own tricks or tools, like one simple patient consultation checkoff list that can be used in the real world of pharmacies. It warns of food interactions, it warns of possible side-effects, it offers lots of other information if necessary. Many pharmacists are using patient information leaflets throughout the province now. This is long overdue. We are starting to move well beyond talking about doing things and we are doing something about it, at added cost to us, at added time to us.

We shouldn't be sidetracked from what we strongly believe is the right thing to do, but we do need the government's support in doing this. We need you to understand the real cost drivers in drug therapy. We want you to join us in focusing on the right thing. Let's make cost-effective drug therapy a reality across Ontario and set an example for the other provinces. But we want you to give us a chance.

We suggest four easy steps initially: Let's define the services and interventions required to achieve credible, cost-effective quality care. Let's define what kind of dialogue between the patient and the pharmacist is required to achieve at least more cost-effective drug therapy. Let's determine the time commitment required by the pharmacist to do this function. And obviously, let's pay the pharmacist fairly to provide these services.

In Ottawa-Carleton this checklist has been used by some pharmacists already. It has been used for some time. We are trying to gain more wide acceptance for this. We're redesigning our pharmacies with private counselling areas, but we cannot expect counselling to be effective if the patient is not offered privacy or offered the opportunity for contact.

Street-level pharmacists are doing their part. We're making our investments to help achieve rational, cost-effective drug therapy with our patients. We would like to see it evolve right across Ontario if it's a possibility. There is a role for government in this evolution and we are seeking a strong partnership to help promote the process and generate some of the benefits we have outlined.

What's the immediate role we see for government? One pressing need is for government to address the appropriate reimbursement of pharmacy services. A single fee, the dispensing fee, that posted fee, the so-called professional fee that focuses on the drug product, does

not reflect the different types of service that the community pharmacist gives today. It's outdated.

We would like the reimbursement to be tied to the provision of appropriate services, with payment based on the type of pharmacy service provided and the amount of cognitive effort required. The joint pharmacy-government task force on alternative forms of reimbursement, co-sponsored by the Ontario Pharmacists' Association, must continue to work on this vitally important issue.

We would also venture to say that the government has an obligation, like health professionals, to do no harm. We can appreciate the difficulty in turning around the ship of state, but it's important to discuss possible courses of action with those who can help shed light on the probable real impact of policy changes. We in Ottawa-Carleton will always make ourselves available to assist government in this regard.

We believe that if the public were better informed, the question of Bill 26 and its impact on drug therapy would be a major public policy issue. The public has a keen interest, as it always has had, in the debate about medicare and its funding. But there is no way that the public is aware of the cost to patients and payors of medication misuse and non-compliance.

We see a major inconsistency in the policy process underlying this particular bill. The copayment is a user fee for necessary drug treatment. We question the legitimacy and fairness of making many of the lowest-income members of our society contribute to the cost of their own necessary drug therapy while vast amounts of money could be saved by reducing the inappropriate use of drugs and non-compliance in the way we have only partially outlined today.

It is not acceptable to make changes that in any way deprive people of essential care before every effort has been made to achieve rational, cost-effective drug therapy. Just give us a chance.

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We are recommending that the Health minister start at once to build on the work we have done at the street level. Through your committee's hearings, we are inviting him to join us on a project with the single focus of achieving rational, cost-effective drug therapy for all Ontario residents. We know this can be done if the key stakeholders work together, giving priority to total patient care.

We would like to suggest four collaborative steps.

Establish a joint task force to implement a simple counselling checklist throughout the province so we can start immediately to get the benefits province-wide that we are already seeing in Ottawa-Carleton with very simple tools such as this.

Maintain the existing joint task force on alternative forms of reimbursement so that a system based on the type of pharmacy service which links payment to treatments and processes that are effective can be put in place.

Work with us to review, refine and implement the best ideas on the improvement of pharmacy services, which we will gather from the street level in all pharmacy associations and pharmacies in Ontario.

Maintain the legislative consultation process with the Ontario Pharmacists' Association. This is imperative.

Thank you very much, Mr Chairman and your committee, for listening to me. I invite your discussion and questions to me or my colleagues. I'd like to wrap up by saying that while we've been in this room, thousands of community pharmacists like ourselves are on the front lines in Ontario every day. They're helping their patients get the most benefit from their drug therapy. They're helping people avoid unnecessary doctors' visits by discussing treatment of their minor ailments. They're providing health promotion advice and illness prevention. In short, they are making major contributions towards cost-effective health care as both drug experts and the most accessible health professionals in Ontario. We hope a stronger partnership can develop between ourselves and yourselves, so that community pharmacists will be able to make a greater and a more valuable contribution to cost-effective health care. Just give us the chance.

Mr Clement: I very much enjoyed your presentation. It gave us a lot to think about, so I thank you for the time you put into that. I want to reiterate for the record a very poignant comment you made, which is that too many people are taking too many drugs. Certainly it is not the intention or the effect, I don't think, of government policy to restrict what is necessary, but we've got to do our part to ensure that the drugs are allocated to the right people at the right time in the right quantity.

You're an interesting group. If I can put it this way, of all the groups we've heard from, aside from the drug manufacturers themselves, you as a provider are probably the most private sector part of this whole edifice. You're primarily a retailer, with some government involvement because of the drug programs.

Mr Tonon: It is very unique, yes.

Mr Clement: I find that very interesting. You've got a lot of worthwhile initiatives in here. Why do we need government involvement with those initiatives? You've got a College of Pharmacists. They've got a quality assurance program they're involved with. Why don't you just go out and do it? Why do you need our approval?

Ms Rosemary Killeen: There is a joint task force on alternative forms of reimbursement in place, with the government and the Ontario Pharmacists' Association studying various ways to implement some of the cost-effective care mechanisms we've talked about. But with the Ontario Drug Benefit Act as it is structured now—and approximately 40% of patients in Ontario who get prescriptions filled are recipients of benefits under that plan—those mechanisms we talked about are not yet in place, and what we're asking for is the opportunity to work with the government to put them in place. I'm talking about linking payments for pharmacists to services provided rather than products provided, making sure that the mechanisms for cost-effective review of patient medications is there as part of the system. Those things are not yet in place. We ask for the opportunity to work with the government to put them in place.

Mrs McLeod: I appreciate the presentation. I'm concerned that despite your valid pleas for consultation, a number of changes, particularly under the Ontario Drug Benefit Act amendments, will affect your practice as pharmacists. I'd like to ask you about all of them, but with the limited time, I'm going to focus on the drug use

management, which you have identified as a concern and as something that needs a positive focus from front-line pharmacists.

I'm concerned when Mr Clement says the government needs to do its part to make sure that people get the right drugs in the right doses. I want to draw your attention to section 23 of the bill, which is the government's view, apparently, of how to have good drug use management, and that's for the government to be able to prescribe the criteria for prescribing drugs. I'd like your comments about whether you see this getting in the way of the professional judgement of both the physician and the front-line pharmacist and therefore of effective patient drug management.

Mr Norman Ferkin: I'll try to answer that. As regards the physician aspect of it, I don't think we can address that. That is purely within the purview of the competency of the physician, and we have never pretended to try to tell the physicians what to prescribe and when. It's purely based on their diagnosis.

As far as controlling the quantity and number of drugs prescribed for an individual are concerned, we have the opportunity when receiving the prescriptions for an individual from a multitude of prescribers, which does happen, to review the totality of their drug profile and predict, by doing so, which drugs may cause problems and which may conceivably be avoided or changed to other drugs, thereby either reducing the cost of the medication itself or preventing possible interactions which will cause further medical costs—not necessarily drug costs, but medical costs overall.

That would be the area where we could input the most.

Ms Lankin: I might have a slightly different focus on this from Mrs McLeod's, because I actually believe that prescribing guidelines are a good thing for the multiple professions to work together to develop. Too many people are having inappropriate drugs prescribed. But I am concerned when I hear Mr Clement say the bill is intended to make sure that the right person gets the right drug at the right time, when the only policy tool they're using is the user fee. I don't understand how that accomplishes that.

Comment on that, but my question is, in addition to prescribing guidelines and drug utilization review, you make the very important point about using your pharmacological expertise and pharmaceutical counselling. What in the bill mitigates against the possibility of moving in the direction you've identified to set out appropriate compensation for those services rendered?

Ms Killeen: At an easy glance, number one, there will no longer be a legislative process existing between the Ontario Pharmacists' Association and the government for any kind of financial discussion with regard to the Ontario drug benefits system. That may limit our ability to discuss or consult on any kind of issue, financial or non-financial. All the kinds of consultative processes necessary to get these valuable programs started are perhaps being completely eliminated by the fact that we will no longer have the ability to speak on behalf of pharmacists in Ontario. We've only had that right by the legislation as it was enshrined, and that's a tremendous

loss to patients in general of Ontario, as well as those on the Ontario drug benefit program.

Ms Barbara Ramsay: If I might also make a comment, with regard to the copay aspect of this legislation, I represent pharmacists to the college, which is the regulatory body as opposed to the negotiating body the ministry deals with on an ongoing basis. The concern here is that the college heretofore has been challenged to control maximum drug pricing; it has no mandate at the present time to control minimum drug pricing. Ergo, when the government puts a policy forth that contains a suggested \$2 copay, it may have rationalized that it feels this is a suitable stipend for the consumer to cover off; the reality is that the pharmacist on the front line, who realizes the importance of the medication to the treatment of the condition as it was so prescribed by the physician, has a real challenge when the financially indigent but very needy patient is in front of them.

What do they do and who is accountable for that? And from a college perspective, as we try to ensure the quality of health care and ensure public health care in Ontario, where is the accountability to the individual pharmacist? In other words, if the person can't pay the \$2 copay, as a pharmacist what do you do? As a college, when do we challenge that pharmacist for poor performance, perhaps negligent performance?

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But from a financial perspective, when does that pharmacist draw the line and say, "This is my professional fee." By the way we would challenge the reworking of this policy to remove the term "dispensing fee." You don't challenge physicians with suturing fees or lawyers with suing fees. They are professional fees, and we deem that the services we provide are in fact professional as well.

So some of these challenges are there, Ms Lankin, absolutely.

The Chair: Thank you. We appreciate your presentation and your involvement in our committee process.

SENIORS ON GUARD FOR MEDICARE

The Chair: The last presenter for the afternoon is Seniors on Guard for Medicare, represented by Art Kube, president; Romeo Maione, chair; June Cassey, vice-president; and Mary Eady, executive secretary. I hope I got those names close.

Interjection: Close but no cigar.

The Chair: Close but no cigar. Oh, well, it's late. Good afternoon and welcome to our committee.

Mr Romeo Maione: We're happy to have been chosen to speak. We're the last, so I guess the last wine is not the best, but there may be a miracle. We're a spontaneous group. We've been conceived just rather lately. Our conception came about with Bill C-91 of the federal government.

The Chair: Excuse me, sir. Could you introduce yourselves so that Hansard knows who's speaking?

Mr Maione: Okay. I'm Romeo Maione and I'm the chair of the group. On my right here is June Cassey, the vice-president. On my immediate left is Mary Eady, our executive secretary, and to my far left, where he belongs, is Arthur Kube, who is our president.

Seniors on Guard for Medicare is a group of senior citizens coming from varying backgrounds who got together spontaneously to enhance medicare. Generally, it was Bill C-91 that brought it all about. When we saw the incredible increase in prices of drugs, we knew that medicare was in trouble. That's what started us going together.

First of all, I'd like to excuse ourselves for some of the mistakes you'll find grammatically in the thing, as senior citizens are not exactly up to date when it comes to computers. That shows you how spontaneous we are. We're not a very professional group.

Most of our members before you were born before 1930. We represent a part of Canadian history when there was sickness and no medicare. We went through the Depression, and many of our members fought in the Second World War against fascism and for the preservation of democracy. It is because of this history that our generation built this country and this province into a more caring and democratic society, and of that we are proud. We hasten to add also that most of these things came about when Conservative provincial governments were installed in Ontario.

At the outset, we want to state that we are extremely upset that the Ontario government would introduce such a wide-reaching omnibus bill, which is a 211-page document with 17 schedules that amend 43 laws, that create three new laws and repeal two others—and which was expected to pass for Christmas—a wonderful Christmas present; I wonder who would have thought about this bill during Christmas—and which, if passed, will have very negative implications for the health care of the people of the province. What makes it completely unpalatable is that the Premier of Ontario has neither asked nor received a mandate for these largely arbitrary changes dealing with health care.

During the election campaign, Mr Harris promised (1) not to cut the health care budget, (2) not to introduce user fees, (3) not to hit seniors and disabled welfare recipients. Bill 26 makes a complete falsehood of these commitments and also flies in the face of Canadian legislative convention, which, if a government is forced because of changing circumstances to make a complete shift in policy, calls for the presentation of a white paper and allows for broad public discussion on that policy change, and not by tabling an omnibus bill, which is very undemocratic to start off with and should only be used as a housekeeping tool once a major piece of legislation is passed. Broad public discussion is exactly what we need, especially in the area of health care provision.

It was a federal Conservative government which appointed the royal commission that brought medicare to this country. It would only be appropriate that Ontario appoint a commission to look at all aspects of medicare and make appropriate recommendations.

Committee members, to be perfectly straightforward, we just don't trust some bureaucrats in Queen's Park with monkeying around with our health care delivery. We didn't get medicare overnight, it took a lot of time, and we demand that you make haste slowly when it comes to changing our health care. The only precedent for such haste and legislative onslaught came in 1983 by the then

Social Credit government of British Columbia, and we don't have to tell you where Social Credit is today. Could it be, just by chance, that Norm Spector is back from Israel and now giving the same bad advice to the Ontario government as he did to the BC government in 1983?

Mrs June Cassey: We want to deal now with some of the specific aspects of Bill 26. Naturally, the first thing that jumps into our face is schedule G, amendments to the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act. While we recognize that there has been a massive increase in the drug costs to an otherwise fairly cost-stable medicare system, we believe firmly that the prescription offered in schedule G is the wrong kind of medicine.

First, user fees are not very cost-effective. The administrative costs would most likely double. Second, these user fees would be a real hardship on the less-well-off and would discourage their seeking treatment they need, leading in the long run to more expensive hospitalization. Third, seniors have planned for their retirement, and that's something that governments have encouraged seniors to do, but now you are saddling us with expenditures which seniors have not planned for. Some of our members were covered by drug plans as part of the retirement package at a former place of employment prior to the Ontario drug benefit plan coming into effect. We doubt that those former employers will be prepared to reinstate that lapsed coverage.

If the government is really serious about reducing the cost of drugs, then it should demand that Ottawa rescind Bill C-91. In addition, Ontario should encourage the promotion of generic drugs and engage in bulk purchases of some of the more expensive licensed drugs, like other jurisdictions have done.

If anyone in the government thinks that deregulating drug prices will bring down the cost of drugs, then we've got a bridge we'd like to sell them. As long as you have five or six monopolies holding all the licences and governments protecting these licences, drug costs will continue to escalate. Doing away with C-91 and making sure that medical discoveries made in our universities stay in the public domain can bring about the stabilization and eventual decrease in the cost of drugs. If the government wants to follow the lead of a famous Tory, it could introduce the Enoch Powell plan, which has prescription drug costs in the UK at least half of ours.

In addition, we have strong concerns about proposed changes to present legislation as proposed in Bill 26, which is projecting four very disturbing trends:

(1) The destruction of confidentiality between patient and doctor by the loss of confidentiality of medical information. These proposed changes are open to abuse and we think are contrary to both the Ontario Freedom of Information and Protection of Privacy Act and definitely in contravention of the Canadian Bill of Rights. Should Bill 26 become law, this issue will certainly end up in the courts.

(2) The centralization of decision-making by bureaucrats in Toronto on what services will be covered, what referrals a general practitioner may make, what medical procedures a patient can receive and what hospital facilities stay open or are closed. If you fine a GP for

making what might be in the opinion of some bureaucrat an unnecessary referral, you have the same situation as you have in the US, where doctors refuse to give first aid on the street in fear of being sued. Common sense tells us that medical decisions should be left to the doctors, in conjunction with their patients, and the issue of hospital facilities should be largely a community-based decision, taking into consideration provincial funding arrangements. 1710

Mrs Mary Eady: (3) The move towards user fees. While hospitals are presently permitted to charge patients for a limited range of insured services, Bill 26 provides explicit authority for cabinet, which probably means the senior bureaucrats in the ministries of Health or Finance, to make regulations which could permit hospitals to charge patient user fees for any hospital-based insured services, including those already covered under OHIP. For instance, the government has already announced that hospitals will be able to charge daily user fees to those patients in acute care beds who are waiting for a place in a chronic care facility or a nursing home. This might not break the letter of the Canada Health Act but certainly prostitutes its intent.

(4) The move towards privatization through independent health facilities. For instance, the proposed changes in Bill 26 to the Independent Health Facilities Act basically eliminate the tendering procedure by giving the ministry the authority to request proposals from specific individuals for the setting up of a private health care facility. To add insult to injury, as a criterion for selecting a provider, the minister can examine the availability of public funding to pay for the establishment and operation of such a facility. For instance, the proposed changes will eliminate the requirement that preference in the tendering procedure be given to non-profit Canadian operators. This will allow the Minister of Health—if we were cynics, we would say his patronage agent—to handpick corporations or individuals to open up shop, even open up franchises of health care clinics that charge people money. We say this is nothing short of bringing American health care through the back door into Ontario.

Although we are an organization of seniors, we nevertheless have to speak out against the adverse effect of Bill 26 on health care and other public employees. Should the bill in its present form become law and the minister use his or her prerogative, indications are that over 20,000 health care workers would lose their jobs. Members of this committee, we have been around and we saw what happened when the government deinstitutionalized mentally challenged adult institutions. Today they are part of our street people, living a miserable life. The health care workers who lost their jobs then didn't get jobs in community-based support facilities because such facilities just were not set up. It is these present health care workers who provide the quality health care to us envied by the vast majority of our neighbours to the south. If you do away with the workers, surely it's understood that you also lessen the quality of health care. We have a moral obligation not to undermine the job security of these workers. Now we'll hear from Art Kube.

Mr Arthur Kube: One more point we'd like to raise, which does not necessarily fall into the confines of Bill

26 but which reflects a penny-wise but dollar-foolish attitude by government: It is the present cutbacks to home care for the elderly, be it for home nursing or home-making services. Some of our members have experienced as much as a 60% cutback in services, creating real hardship for themselves and their caregivers. Because of provincial funding cuts, it is coming to the point where more and more elderly will have to go into institutional care, at much greater cost to the province.

In conclusion, we want, through this committee, to say to our provincial government that Bill 26 is a blueprint for confrontation and division. It's at best a very crude attempt to impose the will of a Queen's Park majority on the majority of Ontarians. The people of Ontario are opposed to the proposed changes to our health care system as contained in Bill 26. The government might get away, in the short run, with the intergeneration game of playing the young against the old, by changing the drug benefit plan and reduced-quality health care. But we advise the Premier and his caucus that this is a dangerous game to play. If you force the pendulum to swing too far one way, it will swing just as far the other way.

If our government thinks that creating insecurity among seniors, among hundreds of thousands of public employees and their families, does not affect the spending pattern, then I would suggest he is either a knave or a fool. Most Ontarians don't even know the real negatives—also, watching television, I'm not so sure that even cabinet ministers do—and the uncertainty already about Bill 26, and also you have to add the federal government cutbacks are extracting already a very heavy toll on the merchant-class support of the government. Ontario's recovery is stalled, and the adoption of Bill 26 will lead us into a massive recession and a further revenue crisis. We ask the government to use some common sense in governing this province. Withdraw Bill 26 and forget about that simplistic tax cut, which ultimately will benefit the very rich. If the government wants to review medicare and health care delivery—because we agree that it's far from perfect as far as prevention, governance and cost-efficiency are concerned, but let's do it properly by the establishment of a commission with the widest possible public input.

With thanks to the members of the legislative committee, all this is submitted as sage advice by the Seniors on Guard for Medicare.

Mr Patten: Thank you for the presentation; it was very good. I see some old friends, meaning length of time I've known you, not any reference to your age, Romeo and Mary.

Mr Maione: Call me a senior friend.

Mr Patten: All right, a senior friend.

Your point relating to destruction of confidentiality between the patient and the doctor, which has come up in more presentations than not, today: Have you had any legal opinion related to the constitutionality of it in terms of the Human Rights Code?

Mr Kube: We didn't get any direct legal opinion, but some of our people in the group have worked in the area of human rights legislation and confidentiality. What they're telling us is, their reading of the legislation is that there's no protection in the proposed legislation against

certain things, be it in terms of communicable disease, be it in terms of drug use and other matters. They are just saying, "Look, there's nothing in there." But they're also telling us—and there again, we listened to news reports, for instance. You have the person who is administering the province's act expressing publicly some real reservations. That sends a signal to us that there might be something wrong.

Mr Patten: All right. We have the same concerns that you do on that one; we're just curious if you had had other legal opinion, because we would love to speak to such legal counsellors if they were available.

A second point that you made in terms of what I'd like to ask you is on the independent health facilities and the two questions you brought up in terms of the authority to request proposals for specific individuals: that the normal procedure of requests for proposals has been taken away and that the right for the minister to even request individuals without tender seems to be an anomaly in normal procedures of public institutions doing business and even in the case of some big businesses, for sure. Have you received any information on the explanation for that from the government, as to what the rationale is behind that?

Mr Kube: No.

Mr Patten: All right. Maybe our friends can answer that at some point.

The last question I'd have is in terms of the apparent increased liability of doctors, with the authority of the minister being able, by way of the general manager of OHIP or whoever, to judge without appeal whether certain procedures or certain tests were done too frequently or if in the public interest or in the interest of a particular individual there was some sort of general malpractice, but it seems to be expanded broadly at this point. Does that worry you in terms of how you think your medical practitioners would be feeling at this particular time in terms of being supercautious and perhaps being slowed down in their ability to respond to treatment for their patients?

Mr Kube: I think it's only logical. The point we made, for instance, in terms of doctors in the United States not even giving first aid on the highway because they're scared they're going to be sued—you're really moving into that sort of system in Canada if you move in that particular direction, and then if a general practitioner thinks he should refer you but isn't 100% sure. Medicine isn't a perfect science; far from it. Surely we should err towards the benefit of the patients. If it would be major abuse—we came in here and we heard that approximately 7,000 people are supposed to have abused it; 7,000 out of seven million? That is not what we might call major abuse.

1720

Ms Lankin: I truly appreciate your presentation. You wrapped up saying it was sage advice, and it's sage indeed. I believe that as elders you carry a moral authority and I hope that is something which has an impact on the government and that it listens. I know the careers some of you have had. I don't know all of you but I know the contributions you have made to building the system we have in place today and to the creation of medicare.

I would like you to reflect on something this committee was told in another town this week in another presentation by a bioethicist. He told us that this legislation and the way in which it's constructed necessarily will lead to decisions about core lists of services, which means certain things will no longer be insured medical services under medicare, and that those things will then be offered and paid for in the private market. He pointed out that there is a constituency of thought in this country that supports a move in that direction, but that that represents a dramatic value change for our health care system, the values that underpin our health care system, and that there has not been a public debate to reach a consensus that it's the appropriate direction to go.

He also said that the value of our health care system is integral to the values of our country and in some ways the self-definition as Canadians, and that this kind of change in this area will affect many other areas of our social interaction and values of our life. I wonder if from your experience you could reflect on that. Mary, I might start with you.

Mrs Eady: It's one of the things that really concerns us. You're right, we did, I believe, do things to help bring about medicare. I think we're keepers of the memory of the community of what it was like without it. I think a lot of people don't understand what it was like to not have the kind of system that we have now. We remember when it wasn't there.

The question of how we decided to establish it wasn't to say, "Okay, we're going to have one system for people who can afford to pay and one for those who can't." We decided we were going to have a system in which we would share in a cooperative way the health costs of the people in the country. What disturbs me as a senior is seeing that concept and that I think principle that made Canada a different country from the path taken by the United States and other countries in the world.

It seems to me that is the thing that's at risk. It's the thing that I think Canadians want to preserve: that question of cooperative caring for each other. I think this kind of push and opening the door, if you like, for further privatization of the health care system really puts those principles at risk and basically changes the face of the country. I don't think it's a small thing at all and it's something that we have to very carefully consider.

I really hope the government does reconsider some of the sections that we've touched upon. To me they're fundamental changes which the Canadian public has not had the time or the opportunity to really debate and to decide what it is they wish to have happen.

Mrs Ecker: Thank you very much for taking the time to come before us and provide your views and comments and suggestions, very much appreciated. As you probably know, there have been some excellent suggestions made through these committee hearings. The government's certainly prepared to consider many of them in terms of enhancing and strengthening this legislation to get on with the important job of restructuring.

Just a couple of quick points. You've expressed some concerns on some items.

One of the things that I said earlier today I'll say again: We are not going to be violating the Canada

Health Act. We're not interested in getting into a point-less or non-productive fight with Ottawa against the Canada Health Act. In fact, this government moved to extend or reimburse or reinstate full coverage for seniors' out-of-country coverage to be in compliance with the Canada Health Act. So we're certainly not intending or doing that and Bill 26 will not be doing that.

Confidentiality: We believe that is protected. There are provisions. But that is also an area that if we need to strengthen and enhance that to ensure that, we certainly will do so.

The other point is the decision of what is medically necessary. The general manager of OHIP in the previous Health Insurance Act had the power to make decisions about what was medically necessary in terms of payments and inappropriate billings. That was made on the advice of physicians. That will continue to be the case in the new legislation so that physicians will be making those decisions. I think that is important.

The Independent Health Facilities Act is legislation that talks about licensing facilities to promote quality assurance in those facilities. The difficulty is that there are many facilities providing health care services that are not regulated under that legislation. There are quality problems, and the intent is to try and bring more of them under that legislation so that we can do the quality assurance activities that have worked so well under the independent health facilities legislation which previous governments had brought in and supported and our government supports. So I think that's important.

It's also important to remember that those regulations for quality assurance apply regardless of who owns the facility, and there are for-profit centres now on licence under the Independent Health Facilities Act. I think those things are important to bring forward.

The quick question which I would like to ask is about one of the things that we've heard: the inappropriate prescribing for many seniors that unfortunately is still occurring for various reasons. A number of people have highlighted it. What advice would you give to the government about how we can work with the stakeholders to try and stop or minimize the inappropriate prescribing for seniors?

Mr Kube: I think what has to happen is that we have to take—for instance, we came together on C-91. I don't know if you people know that for every three medical doctors you have one drug salesman.

Mr Maione: Drug pushers.

Mr Kube: I mean, they're legal drug pushers. I think you always blame the patient, and to a certain extent—

Mrs Ecker: I'm not blaming the patient.

Mr Kube: But sometimes if you go into a drugstore you don't like to pay the filling fee twice, and you know you're on that medicine for a six-month period, so why pay twice? I'm telling you that the push, very largely, for consumption of drugs comes from the industry itself. I think that's where the problem really lies. We know drug costs to the medicare system have increased by 128%.

Mrs Ecker: How would we deal with that with the drug companies?

Mr Maione: License the drug pushers.

Mr Kube: In the first place, you're now going to have a 10-year period where no single generic drug will come on the market because you have more than extended the time limit of licensed drugs. So for 10 years you're not going to have any generic drugs coming on the market. At one time a new drug came on and a licensed drug came off and became a generic drug, and therefore the drug costs balanced each other. But right now, for 10 years you're going to see increase after increase unless you deal with that particular problem. You're going to be in trouble with medicare. We know that.

If you look at the rest of the medicare system, the costs, they haven't skyrocketed. We understand, for instance, that we have some demographic problems which will be coming up. We understand there has to be discussion about health care in this country. The only

discussion we have had in terms of health care in this country is because the President of the United States a couple of years ago started a discussion about health care in the United States, and then all at once Canadians of their own health care system. They went over and became very convinced that what they saw there they didn't like. We don't like to see any wedge coming into our system which moves us towards theirs.

Mrs Ecker: We are not bringing the American health care system to Ontario.

Ms Lankin: That's what the bill's all about.

Mrs Ecker: No, it's not.

The Chair: Thank you. We appreciate your being here this afternoon and your input.

The meeting is adjourned.

The committee adjourned at 1731.

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Romeo Maione, chair	
June Cassey, vice-president	
Mary Eady, executive secretary	
Arthur Kube, president	

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

- *Carroll, Jack (Chatham-Kent PC)
- Danford, Harry (Hastings-Peterborough PC)
- Kells, Morley (Etobicoke-Lakeshore PC)
- Marchese, Rosario (Fort York ND)
- Sergio, Mario (Yorkview L)
- Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

- Johns, Helen (Huron PC) for Mr Danford
- Miclash, Frank (Kenora L) for Mr Sergio
- Clement, Tony (Brampton South / -Sud PC) for Mr Kells
- Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart
- Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

- Chiarelli, Robert (Ottawa West / -Ouest L)
- Grandmaître, Bernard (Ottawa East / -Est L)
- Lalonde, Jean-Marc (Prescott and Russell / Prescott et Russell L)
- McGuinty, Dalton (Ottawa South / -Sud L)
- McLeod, Lyn (Fort William L)
- Morin, Gilles E. (Carleton East / -Est L)
- Patten, Richard (Ottawa Centre / -Centre L)
- Rollins, E.J. Douglas (Quinte PC)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Campbell, Elaine, research officer, Legislative Research Service

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of Ontario**

First Session, 36th Parliament

**Assemblée législative
de l'Ontario**

Première session, 36^e législature

**Official Report
of Debates
(Hansard)**

Friday 12 January 1996

**Journal
des débats
(Hansard)**

Vendredi 12 janvier 1996

**Standing committee on
general government**

Savings and Restructuring Act, 1995

Health issues

**Comité permanent des
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Friday 12 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Vendredi 12 janvier 1996

The committee met at 0900 in the City Hall, Kingston.

SAVINGS AND RESTRUCTURING ACT, 1995

LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Welcome to the hearings on Bill 26 conducted by the standing committee on general government. We're delighted to be here in Kingston in this magnificent building. Obviously you people are very fortunate in Kingston to have buildings like this. We're delighted to be here.

I just want to let you know that the dialogue is between the presenters and the members of the Legislature sitting at the table. We're delighted to have so much interest from the audience, but I would expect that the dialogue would be kept between the people at the table, just to forewarn you about that.

Before we call our first presenters, I understand that there's a motion. Mr Gerretsen.

Mr John Gerretsen (Kingston and The Islands): Yes, I have a motion.

Whereas Bill 26 will have a major impact on every individual in Ontario; and

Whereas Bill 26 requires broad public input before being passed into law; and

Whereas there are nearly 60 groups in Kingston that want to provide input into the bill but only 16 will be heard; and

Whereas the community of Kingston only has two half days of hearings;

I move that when the House returns on January 29, 1996, the order with respect to Bill 26 be amended such that the portions of the bill that do not require urgent passage for fiscal reasons be returned to the standing committee on general government so that further hearings can be arranged across the province, including the community of Kingston.

The Chair: Thank you. In other cities where this motion has been introduced we've delayed discussion on it until lunchtime. Since we don't have any opportunity for lunch today, is there a possibility for all-party consent

to a two-minute maximum for one person to speak for each party and, if there is, we'll discuss it now?

Mr Tony Clement (Brampton South): Agreed. Is there a written copy of this motion?

The Chair: We'll pass out the written copy. If we have all-party agreement to one person speaking for a maximum of two minutes, we'll discuss the motion and dispense with it now, please.

Mr Gerretsen: As has become quite clear not only in these hearings, I'm sure, since it's the first day that I'm involved with these hearings, but I've been involved mainly this week, for the other four days, with the evidence hearings, which is the parallel committee holding hearings across the province as well, there are roughly three times as many groups in every community that want to present on a daily basis than there is time to hear the presentations.

It seems to me from what we've been hearing, and undoubtedly I understand from what you've been hearing here as well, that people want more time to discuss the implications of this bill. There is a wide-ranging aspect as far as what's involved in the bill—it deals with just about everything under the sun—and it's our feeling that only those areas that deal specifically with the immediate fiscal impact as it relates to the province of Ontario should be dealt with on January 29. There's interest in it. People want to talk about it.

I have great reservations about the hearings that have been held. To call them "public" consultations, quite frankly, is stretching the word. I know there was an agreement among the parties, it was reluctantly agreed to by both opposition parties to have two weeks of hearings outside of Toronto, but the point still is that we really haven't had true consultation. True consultation means a dialogue on what's in the bill and the various aspects of it. I think what we're really getting across the province are presentations and, usually in two or three minutes, quick questioning on very minute aspects of the bill.

In any event, I'm here to present this motion. I also would like everyone to know that following the adjournment of these hearings this afternoon, we will be holding parallel hearings when at least two other members of the opposition will be joining me for hearings this afternoon for those people that couldn't present during the morning.

Mr Rosario Marchese (Fort York): I'm happy to support this motion. As some of you know, Frances Lankin, my colleague, has moved a similar type of motion in the past, and I would have done very much the same based on the past experience. I read through Hansard and there have been a number of people, if not the entire group, who have come forward and said, "We need more time to assess the implication as it relates to

the specific profession and as it relates to communities as a whole." This bill was so hastily prepared and introduced in a mulish sort of way, I would say, that it has not given time to anyone to assess what the implications are to our communities.

We know there are more people who want to depute than there are spots for, because they feel the issue strongly based on what they're hearing, not so much based on what they're reading because many can't even get a copy to read. Based on their fears of what they're hearing, they want to be able to come before the committee to state their concerns, although more and more people are now getting access to specific portions of Bill 26 that affect them particularly and in a general way. We feel it's the essence of democratic participation that people be given that opportunity.

Given that Bill 26 affects us so greatly, because of the extraordinary powers it gives to cabinet and to particular ministers, we believe that, because it changes much of what we have understood in the past, people need that opportunity. I'm very happy to support this motion and hope that some of the Conservative members on the other side will reconsider their past positions on this matter.

Mr Clement: I find myself speaking against the motion. I understand the rationale presented by Mr Gerretsen but I guess I disagree with the premise a bit. I think that the public process is working quite well from a number of different perspectives.

Firstly, on both sides of the committee, both the health and the non-health, the total number of presenters by my calculation will have reached 750 by the end of this process. Dealing with the health side, if I can speak for my colleagues, there has been a very high quality of discussion by the presenters representing their communities, labour or the pharmacists or the doctors or the patients.

We've had a very diverse group of people in every community, and I expect the same in Kingston today. That diversity of representation also has reflected a multiplicity of views, some favourable to what the government is doing and some very unfavourable to what the government is doing, and that's what this process is all about.

From my perspective, it has been very helpful at least to the government side, and I suspect for the other side as well, to hear from these groups. They have helped us grapple with what potential amendments we may wish to deal with in the third week of January.

I note that the motion talks about not requiring urgent passage for fiscal reasons, those sections that don't deal with the fiscal realities of the province. But there's also another facet of these particular schedules in this committee, which is the need for urgent passage for health reasons. We currently have a health care system which is mired in the status quo, which means that there are empty hospital beds that we as taxpayers pay for, yet we have such urgent needs in our communities: urgent needs for long-term care, urgent needs for palliative care, urgent needs for HIV sufferers, urgent needs for cancer sufferers.

Those are urgent requirements as well, I would say to the mover. They may not be fiscal reasons, but they are

health reasons, and the sooner we can restructure our health care system to provide the health care that is necessary for Ontarians the better we are all—

The Chair: Thank you, Mr Clement. Before we call for the vote, I just want to let you know there are only five people at the table who have the chance to vote because they are the five official people of the committee. There are three representatives from the Conservative Party, one from the New Democrats and one from the Liberals, just if you wonder why some people are not putting up their hand on the vote.

Those in favour of Mr Gerretsen's motion? Those opposed? The motion is defeated.

Mrs Lyn McLeod (Fort William): I did have a second point to raise, obviously not to debate a motion which we know, with the voting odds stacked in a way that you've just described to the audience, we have no hope of winning unless the government realizes that there are significant numbers of people, including people in this audience, who want to make a presentation, who should be heard because this bill affects them very directly and who do not have the opportunity to be heard in this community and in many other communities.

I want to draw to the committee's attention the fact that one of the groups that cannot be heard this morning in Kingston is the physicians of this community, the Kingston Academy of Medicine. That is clearly a group that, in Mr Clement's own terms, is affected and should have been heard.

Mr Chairman, I want to draw your attention to the fact that the Kingston Academy of Medicine, because they could not get on the agenda, have tabled a written brief. I think it's important that people know that they have made a presentation and that they are present in the audience today.

The Chair: Okay, thank you, Mrs McLeod.

0910

PROVIDENCE CONTINUING CARE CENTRE

The Chair: Our first presenters this morning represent the Providence Continuing Care Centre: Guy Legros, the president and CEO, Dave Bonham, chair of the board, and Sister Sheila Langton, vice-president of the Providence health system. Good morning and welcome to our committee. You have a half-hour of our time and questions, should you leave the opportunity for them, would begin with the New Democrats. The floor is yours.

Sister Sheila Langton: Thank you, Mr Chairman, for the opportunity today to appear before your committee and also for the public hearings on this important legislation. I am going to begin the presentation with a very brief community and service profile of Providence Continuing Care Centre in Kingston, and Mr Bonham then will deal with our concerns regarding Bill 26 and our recommendations.

Providence Continuing Care Centre is a Catholic health care organization sponsored by the Sisters of Providence of St Vincent de Paul, offering a continuum of services in the long-term-care field.

My community, the Sisters of Providence, have ministered to the health, education and social needs of the

citizens in the Kingston area since 1861. The mission of the sisters over the years has been to develop and provide services for which there is an identified need and no other existing service to meet that need. The goal of the programs offered by Providence Continuing Care Centre is to provide compassionate, holistic care to those requiring long-term-care services. Care is delivered with sensitivity to the dignity and wishes of the recipient, within a context of the individual needs of patients, residents and clients.

The sisters have worked in partnership with the community from the beginning to identify the changing needs of its citizens, primarily in the field of long-term care. The linkages they have developed with consumers and other health care providers have contributed to a well-coordinated health system in the Kingston area. Over the past 10 years Providence Continuing Care Centre has participated in the rationalization of a variety of clinical program streams among area hospitals.

Indeed, St Mary's of the Lake Hospital has been identified through a community planning process as the future single site for all rehabilitation services in the greater Kingston area. The hospital at this moment awaits a Ministry of Health response to its request to transfer rehabilitation programs from Hotel Dieu Hospital and Kingston General Hospital. St Mary's has also requested a capital subsidy in order to renovate St Mary's premises to accommodate the incoming rehabilitation services.

Just to give you a very brief service profile, Providence Continuing Care Centre offers a number of community and institutionally based services funded primarily by the Ontario Ministry of Health.

We have St Mary's of the Lake Hospital, a 223-bed chronic care and rehabilitation hospital serving a six-county regional area. The hospital provides continuing care, geriatric medicine, rehabilitation medicine, palliative care, respite care and a day hospital. Services are increasingly delivered on an outpatient basis.

Providence Manor, a 223-bed long-term-care facility, provides nursing care in a homelike residential environment for seniors who can no longer remain in the community.

The regional community brain injury service program offers residential and community-based assessment and treatment services to victims of acquired brain injury in the six counties surrounding Kingston. This program has already repatriated a number of individuals receiving care in the United States and has developed the infrastructure necessary to prevent further referrals of people from their areas to services outside Ontario.

Under the umbrella organization as well, we have the attendant care program. It provides attendant services in the home and in a residential supportive housing program to 52 severely physically disabled adults in Frontenac, Lennox and Addington counties at any given time.

The Hildegard Centre is an adult day centre which provides personal care, counselling, activity programming and respite care for aging seniors living alone or with family members in the community.

I think that gives you a bird's-eye view of our umbrella organization, Providence Continuing Care

Centre, sometimes called PCCC. I'll ask Mr Bonham to continue with our concerns.

Mr David Bonham: Thank you, Sister Sheila. I want to say on behalf of Providence Continuing Care Centre that we're very happy to be able to meet with the committee today and to talk about some of our concerns.

We certainly recognize the need that the government has to tackle some of our problems relating to the deficit etc, and we don't quarrel with that in any way. As a matter of fact, we strongly support those efforts. But we're concerned to some extent with the impact of Bill 26 on our organization particularly—we'll be speaking from that perspective only—and we're concerned about some of the powers and the procedures and the implications we see in this, and I think that is a common concern of everyone here.

If I'm not mistaken, this bill has been referred to by the government itself as its toolkit, so we're here to talk about the tools the government needs to do this job, and the shape of those tools and the size of those tools and the number of those tools. I would also like to say as a corollary to that that I hope the members of the committee recognize the fact that we have a job to do as well and we need some tools. Therefore we want to talk about those things, in what I hope will be a constructive way.

There are some very broadly based powers here. We recognize that some of these may be necessary, but those are certainly areas of concern.

I would also like to address one other broad theme that runs through our deliberations, and that is the impact that these developments and others might have on—

The Chair: Can I ask you people to remove those signs, please. No signs, no protests allowed in here. Please remove the signs. Sorry for the interruption. Carry on, please.

Mr Bonham: I was about to say that one of our ongoing concerns generally, and not only with regard to this legislation, is the effect the changes may have on the voluntary governance of organizations such as our own. In saying that, we recognize very clearly that changes are necessary. We're not opposed to changes. The society we live in is changing, and we must change with it. But as Sister has pointed out, the Sisters of Providence have been a very active and positive part of this community since 1861, since before there was a Canada, and we intend—hopefully—to be here for a long time yet, doing the work we have been carrying on for those many years. That, I will say very clearly, is a concern we have.

0920

Following up from that, some of the powers in Bill 26 we feel could have—and I say "could have," not necessarily will have—an adverse effect on the voluntary governance of our organization, and we want to raise those concerns. I'm not going to go into detail, and you've been through this before many times, but some of the powers that are described in schedule F, part II, section 6, including the power to close hospitals, to increase or decrease services, to direct the boards of various hospitals to amalgamate, could have the effect of impacting on our right to conduct our own affairs. Also, we've noted the expansion of the powers where a hospital supervisor can be appointed by the Lieutenant Governor

in Council to exercise all the powers of the hospital board. That could very clearly interfere with the independence of an organization.

We're not saying that these powers are absolutely unnecessary, and there may be a case to be made to have them, but we would like to suggest that these are very extreme and unusual powers and they're not the normal powers that one would expect to find in a democratic society such as ours. We would ask the government to recognize that these are extraordinary powers and that these are unusual times. Therefore, our first recommendation in this area is to strongly request that there be a sunset clause on some of these extreme powers. If they are necessary, and I think that's a government decision, our position is that they should not go on forever. They should be recognized as being unusual, and there should be a sunset clause so that at some appropriate time, further meetings such as this will be held to discuss whether they are still necessary. We would strongly request that consideration be given to that approach.

We also hope that in whatever manner these powers or others like them might be implemented, there will always be recognized the need for consultation as full as possible with the parties involved. Without suggesting any bad intent or being negative, some of these powers could be seen as being arbitrary, and we hope that in our society we will do everything possible at every stage to try to avoid that kind of result. Therefore, we leave that as the second recommendation. Admittedly, it's a very broad recommendation, and we're not trying to shape it in a specific way, but we sincerely hope that attitude will go through whatever develops as a result of these hearings.

We're also concerned about the broadness of the catch-all provision in the draft legislation whereby it's possible to "make any other direction related to a hospital that the minister considers in the public interest." If it is necessary to have such a broad power, this might be referred to, I suppose, as a supertool if we're talking about a toolkit here. This is a very powerful tool, and if it is necessary to have such a tool, we would hope there might be some way to establish boundaries or limits or some further specifications related to it. There's nothing one can imagine in the field that would not be captured by such a broad provision, and we really wonder whether a provision of that extent is necessary in this toolkit.

I'd like to shift now, recognizing the constraints of time, to a few brief comments about the hospital restructuring commission. We recognize that we may be in a period of reorganization and restructuring, and all of us of course are concerned about how this might play itself out. While, according to my understanding, the detail of this has not been fully determined, it appears that there may be some delegation of authority from the government to the restructuring commission, and that is something that really does concern us. If it is necessary to take some of these extreme decisions—and I only say "if" it is necessary—we are then concerned with whether they are delegated.

We would strongly recommend that the restructuring commission be seen only as an advisory body to government so that it does not have, in and of itself, the power to make final determinations. That is certainly a recom-

mendation we would like to leave with this government. We feel that if it is necessary to take some of these decisions, they should be made at the highest level and accountability for them should be seen to exist at that level.

We would also like to request that in whatever work the hospital restructuring commission might do, it be requested to respect the government's commitment and I believe the Premier's commitment to the voluntary governance of hospitals such as our own. I have already said this and I don't want to repeat myself, but we do feel that there is some possibility of erosion and difficulty for us in this area. We'll leave that recommendation with the committee.

I would now like to make a few brief comments about the labour situation and the arbitration provisions etc. We recognize that in any restructuring the role of labour is going to be very significant. We are very concerned about the impact of some of these things in our capacity as an employer as well as in our capacity as a provider of services. We certainly want to treat our staff, who have been so loyal to us for so many years, in a very positive way. But we do recognize that labour costs are part of the discussion and they will be part of the future development in this province.

We have of course noted the provisions in the draft legislation relating to the requirement that arbitrators consider certain elements, which will include ability to pay. We recognize the good intent that lies behind that. We are concerned, however, with how effective that will be. Again, I don't want to be negative, and we don't have time to go into detail, but I think it's fair to say that the history in this area in Canada has not been entirely positive in terms of giving directions to arbitrators, and I'm not negative towards arbitrators in saying that.

Our recommendation is that we would request that the government implement a more precise mechanism for achieving these objectives. Rather than delegating that in a very broad sense to arbitrators, we would recommend that some consideration might be given to a legislated moratorium on salary awards or a salary rollback or some other such device which would be established more directly to achieve this, with the hope that in the longer term as much as possible can be preserved in our collective bargaining process.

In a related vein, we would also request that more latitude be given to us in any restructuring in this very difficult question of contracting out. We recognize that there's a long history—I'm not going to even mention it beyond that—and we know how sensitive this is, but it will become a very important part of the process. We are concerned about that and we would hope that in the longer term this can be done in a way that will be in the best interests of the citizens of the province and of its workers. We would therefore ask that some further consideration be given to this issue of contracting out.

The last item I would like to refer to, and I'll do so quite briefly, is an important one in so far as it affects our organization and our style of operation: the Ontario drug benefit plan changes. We know these items are all very difficult and very broad, and it's easy to be critical and negative, and financial considerations are important,

but most of the residents of our long-term-care facility, Providence Manor, are really not well-off at all in a financial sense. We hope they're well-off in other ways, I might add. Finances are very difficult, and many of them—not all of them, of course—really have just a little over \$100 a month for their own needs. If my information is correct, and if these charges go through, we could find people in these circumstances with virtually no disposable discretionary funds whatsoever. Therefore, we want to draw this to the committee's attention. We feel it is an important issue, because a little bit of quality of life and freedom to make those kinds of decisions, for people who are in those circumstances, is extremely important.

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Therefore, we would ask that there be a further consideration given to these recommendations as they now exist which might provide for an exemption for the residents of long-term-care facilities from the user fee for drugs, or certainly a review of that situation.

Mr Chair, I realize that time is very pressing. There are many, many other things that we could have addressed. We have attempted to select just those few items which we felt were of particular relevance and importance to Providence Continuing Care Centre. We wish you well as you grapple with these important issues. I hope some of the things that we've said relating to the tool chest the government is building will be helpful and will allow us to do the job and we hope you will take these views into consideration for the overall best interests of this province. Those are all the comments that I want to make.

The Chair: Thank you. We've got a short time left for questions, about two and a half minutes per party, beginning with Mr Marchese.

Mr Marchese: Thank you, Mr Bonham and Sister Sheila, for your presentation and comments. I appreciate the gentle and restrained critical approach you're taking to this bill and to the Tories. There may be a reason. I'm not quite sure why you have been so gentle.

Mr Bonham: Because we're reasonable people.

Mr Marchese: Oh, I see. So far I have not witnessed that, but there's still time for that to change.

You talked about the ability through this bill to appoint a hospital supervisor who would have similar powers of the hospital board, and you're again in your gentle way saying it might be necessary but you don't quite agree with that.

We don't agree with that kind of power either. We think that if the government intends to do something as it relates to hospitals and it requires a change in the bill, or a bill, that it should be presented in the House for debate, giving the opposition the opportunity to be able to talk about those changes, giving as well the public an opportunity to hear the discussion, the debate, to bring it, if it's a change to a bill, after second reading to committee to allow people the opportunity to discuss. We think that's part of the democratic process.

This does not allow for that. So I'm sure you don't want to be gentle in saying this is wrong. We shouldn't apply a sunset clause to it. It's fundamentally wrong. Do you want to perhaps rephrase some of your comments around that?

Mr Bonham: Thank you very much for that kind of invitation to be more direct. We recognize the points you make. In our considerations, we have not yet been able to envisage a situation where this would be invoked.

Mr Marchese: So we don't need it then.

Mr Bonham: Well, we feel it is not necessary. What we were hoping to achieve is that realistic limits would be set on it in some way. It's the open-endedness of it that disturbs us more than anything, without any test or criteria.

The Chair: Thank you, Mr Marchese. For the government, Mr Clement.

Mr Marchese: Ah, time flies.

Mr Clement: Thank you very much for your important comments. Certainly you gave us quite a bit to think about and I thank you for adding your comments to the process.

With respect to supervisors, just since that's where Mr Marchese left off, I might add parenthetically that his colleague Frances Lankin has said at previous committee hearings earlier this week that she did recognize the need for some tools for hospital restructuring and we were quite excited by her comments on that.

Mr Marchese: Depending on what those tools are.

Mr Clement: Let me just talk a bit about the hospital supervisor, because of course that was in the previous legislation, as you well know. This is not a new concept that we are proposing. There are some changes, though. We eliminate the 30-day waiting period, and obviously we want to deal with situations where there's been a paralysis in the hospital environment. In a particular hospital maybe the entire board has resigned or there's something going on that might affect the quality of care in a community. If we focused in on those reasons to appoint a supervisor, would that satisfy you?

Mr Bonham: That would certainly go a very long way. I think it's the broadness of it, just the very open and unrestricted situation that we now see, that gives us the greatest concern. I think that would be helpful, certainly. Again, without knowing just what those issues are, it's hard for me to go beyond that.

Mr Clement: Sure. Let me turn then quickly to, you emphasized the need for local consultation. I think that's absolutely critical for the restructuring commission to do its job properly. I might add that under this Bill 26 we did not mention district health councils. So in fact that means that their current powers—their advisory powers, their planning powers—which are enshrined in the current legislation, are not changed; they're still there. If we made that more explicit, the connection between the district health councils and the groups that they represent and the restructuring commission, would that satisfy you?

Mr Bonham: Again, that would be very helpful. It was a broad issue we raised. We were not trying to be specific as to how the consultation would take place. Our only concern is that somewhere in the process, on a timely basis, there is a real opportunity to have views made known by the parties that will be involved. I don't think we're particularly concerned just where that is in the process, whether it's at district health council or somewhere else. We want to be heard if we're going to be involved. That's what we're saying.

Mr Clement: Quite right.

Mr Gerretsen: Mr Bonham, I too have been impressed with your gentleness about the entire situation. But Providence Manor and St Mary's of the Lake Hospital have been operating for over 135 years. It's a privately organized institution and has been for years run by the sisters, and very effectively so.

You've read schedule F of the act. The minister is not bound by any regulations under the Public Hospitals Act. He has unilateral power. "The minister may direct the board of a hospital to cease operating."

Now, I can see how a minister could say, "I'm not going to give you any funds any longer," but it's a private organization, started by a group of private individuals here. How can a minister, in your opinion, just unilaterally, without the consent of the Legislature, tell a private organization that's been operating for over 140 years in this community, "Now you will cease operating"? Don't you think that those are extreme powers?

Mr Bonham: Absolutely. I hope that nothing I said indicated that I felt otherwise. I may have been accused of being gentle, which is certainly not the worst thing I've ever been called—I'm not going to tell you what that is—but, yes, those are very extreme powers. And maybe I don't have an active imagination, but I cannot imagine a situation where that could be justified in any manner. I think what we would be talking about in a real life situation, if such ever developed, would be a set of circumstances where there would have to be some justification. If that was done just as an arbitrary thing, it would be a declaration of war.

Mr Gerretsen: But of course he doesn't have to justify it now.

Mr Bonham: No, I realize that.

Mr Gerretsen: Under regulations he would have to justify it. Under the way this stands in this act right now, the way it's proposed, he can just do it unilaterally, without any kind of liability to him either.

Mr Bonham: The door is open. We feel that is far too extreme, frankly.

The Chair: Thank you very much, folks. We appreciate your presentation this morning.

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SOUTHEASTERN ONTARIO HEALTH SCIENCES CENTRE

The Chair: The next group is the Southeastern Ontario Health Sciences Centre, represented by Terry Stafford, John Marshall, Robert Maudsley, Guy Legros and Paul Rosenbaum. Good morning, gentlemen, and welcome to our committee.

Dr Robert Maudsley: Good morning, Mr Chairman, members of the committee. Thank you for the opportunity to speak with you this morning. We are representatives of the Southeastern Ontario Health Sciences Centre, and in a moment—

The Chair: Excuse me. So Hansard can record it correctly, I wonder if I could get each one of you to identify yourselves so we know who's speaking.

Dr Maudsley: Yes. I'm Robert Maudsley, the vice-dean of medicine, Queen's University.

Dr John Marshall: I'm John Marshall, chief of staff, Kingston General Hospital.

Mr Terry Stafford: I'm Terry Stafford. I'm the chairman of Hotel Dieu Hospital.

Mr Paul Rosenbaum: I'm Paul Rosenbaum, director of planning and secretary to the health sciences centre.

Mr Guy Legros: I'm Guy Legros, one of the CEOs of the member institutions of this centre.

Dr Maudsley: If I just may make a couple of brief remarks before Mr Stafford will speak to our brief, Southeastern Ontario Health Sciences Centre represents six organizations. Those not at the table today are the Kingston Psychiatric Hospital and the Kingston, Frontenac and Lennox and Addington Health Unit.

We're a voluntary group. We work together. Simply put, our objectives are to have the most effective health care and medical care for the citizens of southeastern Ontario. Secondly, we prepare health professionals for the future, and we are very actively engaged in health care research. That's our broad mandate. We work very closely and cooperatively to try and foster those missions in this region. I'd ask Mr Stafford to speak to you, sir.

Mr Stafford: Our objective in this submission to the standing committee on general government is not to present a clause-by-clause analysis of Bill 26, nor do we intend to suggest a specific wording to correct problems in this bill. You are aware of the position taken by the Ontario Hospital Association in its submission to the committee. We agree with it. We do not intend to repeat the OHA's detailed suggestions with regard to wording change. Rather, we wish to address the basic principles underlying this legislation and to identify some areas in which the legislation actually subverts the government's principles rather than supports them.

The position which we take in this submission is not unique to the hospital sector. Similar concerns have been expressed to you by other providers of health services. We note, for example, the excellent submission by the Association of Ontario Health Centres.

Please recognize the significance of the similarity of our concerns. The Association of Ontario Health Centres represents providers of primary care health services and of health promotion programs serving small, underserved communities. Our members, on the other hand, represent the other end of the health care continuum. Kingston hospitals are tertiary care teaching hospitals providing the most sophisticated treatment services to Ontario's most severely ill patients and those with the most complex illnesses. From both ends of the health care continuum, you will have heard support for the principles of the draft legislation, along with a limited number of legitimate and deep concerns about how some of Bill 26 attempts to address these.

The objectives of Bill 26 espoused by the Premier, the Honourable Mike Harris, and by the Minister of Health, the Honourable Jim Wilson, are consistent with the broad policy framework clearly set out in the Common Sense Revolution. Throughout the election campaign, the Progressive Conservative Party clearly enunciated principles which would guide them in setting policy for health care in Ontario. We believe in these principles. We wish to see the proposed legislation amended to make it

more consistent with these principles and with the policy objectives of the government.

Repeatedly, the government has stressed the need for genuine partnerships between it and its transfer partners, such as hospitals. The role of government is to set policy, establish standards and define the objectives by which public institutions must operate. The role of our public institutions is to manage their organizations in accordance with policy established by the government.

Bill 26 confuses these roles. Bill 26 would provide the Minister of Health with broad powers, indeed unprecedented powers, to direct and to manage individual health care organizations. Government should set policy for management, but it should not, and indeed it cannot, directly manage individual health care agencies.

The legislation would allow the Minister of Health to write hospital bylaws, thereby deciding the basic internal rules by which hospitals and their staff will operate. The legislation would allow the Minister of Health to determine the specific services to be offered within individual hospitals, and even the specific levels of service. These are not powers to establish policy, but rather the power to manage the day-to-day operations of the hospital.

We do not believe these new powers are necessary, nor do we believe they are consistent with government objectives. The Minister of Health, the Honourable Jim Wilson, in speaking to the annual meeting of the Ontario Hospital Association, said:

"At the Ministry of Health...we started by asking ourselves some fundamental questions, such as 'What is our core business?' 'What should we be doing and what can be done better by someone else?'"

"To answer my own question, our core business will move from the position of direct service provider to that of strategic system manager. In the words of Peter Drucker, we will be 'steering, not rowing.'"

The impression is that these broad and often unrestricted powers move the government from partnership to direct management of individual hospitals. Mr Wilson said that the government would work with the hospitals "jointly and individually, each working in our respective spheres." Give government the tools to set policy. Let hospitals give the tools to manage in accordance with those policies.

Approximately one year ago in the Mike Harris Forum on Bringing Common Sense to Health Care, called "Bringing Common Sense to Health Care," the Progressive Conservative Party identified goals for the health care system. We support this document, which called for "a coordinated system of management, with health care professionals leading the way, working with government and incorporating community and consumer concerns." In part, Bringing Common Sense to Health Care promised "improving management and accountability at all levels of the health care system to make it more responsive and accountable to the people who provide care and the people who receive it."

Bill 26 in its present form will not improve management and accountability. Bill 26 threatens our collective ability to manage the health care system by allowing those responsible for developing policy directions to attempt to manage the health care system. Paradoxically,

the bill would provide a disincentive to effective hospital management by allowing, or requiring, that difficult decisions be kicked upstairs to the government in Toronto. Effective hospital management must be in the hands of those in our hospitals and communities. This was clearly recognized by the government prior to the election, and it has continued to be the government's policy objective since coming to power.

Bill 26 attacks the systems of accountability which currently exist. The bill gives government unrestricted powers to write bylaws, unrestricted powers to determine the types and levels of service that should be provided, and unrestricted powers to set conditions for funding and thus micromanage the day-to-day operations of the hospital.

One year ago, the Progressive Conservative Party wrote in Common Sense: "We believe that Ontario's health care system would benefit from a team approach to management at all levels. Under our approach, professionals would be encouraged to bring innovative ideas forward and assist in system management, creating more of a team environment. This would lower barriers between professionals and management and focus everyone on improving health care for the people of Ontario."

By granting the Minister of Health the power to manage individual hospitals, team-building is undermined. Are all of these new powers necessary, or even helpful? We do not believe so.

The Minister of Health can meet his responsibility to oversee the hospital system and to ensure compliance with government policy in a number of ways. The requirement that the ministry approve hospital operating plans, the power of the minister to approve changes to hospital bylaws, the right of government to set funding levels, and the right to appoint a hospital supervisor are some of the ways that government can ensure hospital compliance to government policy, and they do not undermine the ability of hospitals to manage their own affairs.

Bringing Common Sense to Health Care recognized the need to continue strong community involvement in health care and to foster community involvement, promising "to give communities more say in establishing their own local health care priorities, as well as how and where they want health care services to be provided."

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Bill 26 in its present form does not foster community involvement. Bill 26 threatens a community's ability to make decisions about health services. The current Public Hospitals Act allows the minister to veto changes to hospital bylaws. We believe the change from the veto power to the power to create hospital bylaws is a significant and unnecessary, perhaps dangerous, new power. Under Bill 26, there are no substantive decision-making powers left exclusively to the local hospital board. All of these may be superseded by decision-making by the Minister of Health. With the power to write bylaws moved from the hospital to Queen's Park, the board becomes a shell. We believe this threatens the voluntary nature of hospital governance which has been the strength of Ontario's hospital system.

At the Ontario Hospital Association, the Minister of Health said: "You have asked the government to affirm its commitment to hospital voluntary trustee governance. Yes, I am doing that today." Bill 26 may threaten that commitment.

Last year, the Progressive Conservative Party noted that "For too long, the public has been a silent partner in important health care decisions, and has had to defer to politicians and administrators to manage Ontario's health care system.... In too many cases, there has been no real consultation with the public before services which people value highly are reduced."

Despite the policy objective of what was at the time termed "true consultation," Bill 26 does not require consultation even on the single most significant reduction of service: the closing of a community's hospital.

We understand the need to restructure Ontario's health care system. We agree that the health system must be restructured. But ultimately there must be public accountability for decisions which may profoundly affect individuals and communities. Under the proposed legislation, an appointed commissioner may close or order the amalgamation of hospitals without public consultation and without the express approval of the Minister of Health. We believe such decisions should not be delegated, and must rest ultimately with the Minister of Health.

In *Bringing Common Sense to Health Care*, the Progressive Conservative Party identified the real need to ensure the rights of our patients. The paper called for treatment which "recognizes one's privacy, dignity, and individuality." But under Bill 26 this principle is undermined. Simply by using our hospitals, our patients will be seen to have given consent to the disclosure of information about treatments received. Bill 26 threatens the privacy of the patient. A patient's use of the hospital cannot be seen as having freely given consent to the release of personal medical information.

Further, the minister may enter into agreements with others to collect or release such information. Under Bill 26, the minister would not only have the right to release information about the services received, but also could allow others to use such information. The unrestricted right to release patient information from the medical record risks the privacy, dignity and individuality of our patients.

We are given to believe, from reports in the press, that the government intends to amend this section of the bill. The release of information from the medical record tied to the names of individual patients is not necessary for health care system management.

We believe the principles underlying Bill 26, principles which we endorse, may be better supported through a number of amendments. Underlying our suggestions is the belief that broad new powers should only be given to government where they are truly needed.

First, where there are to be significant alterations in hospital operation, such as closure, amalgamation, or major program alterations, hospitals and the local communities should have the opportunity to comment before change is implemented in order to ensure community participation in health care decision-making.

Second, significant alteration in hospital operation should require the concurrence of the Minister of Health in order to ensure public accountability.

Third, language granting the minister power to manage hospitals on a day-to-day operational basis should be amended to provide only those powers necessary to ensure adherence to government policy and the sound local management of the hospital.

Fourth, volunteer hospital boards should be supported, as should the board's rights and responsibilities to establish bylaws and oversee those people they select to manage the hospital.

Lastly, privacy of patients should continue to be protected.

We urge the committee to consider the detailed proposals for amendment made by the Ontario Hospital Association and others.

Thank you, Mr Chair.

The Chair: Thank you, gentlemen. We've got about three minutes or so left per party for questions, beginning with the government.

Mrs Janet Ecker (Durham West): Thank you very much for coming today and putting in a lot of work and making some very excellent suggestions in your brief and submission. If you have any further comments or suggestions, we would certainly encourage you to make sure they are submitted to us.

I'm pleased to see that you recognize the principles of the Common Sense Revolution and the restructuring in health care and what we're trying to achieve here. I also appreciate that you have some concerns and suggestions about how the bill may well be amended.

As you know, the confidentiality area is something that has provoked concern from some individuals. Certainly, the protections for confidentiality that were there before within various legislations we believe are still there, but if there's a way to enhance that, we're prepared to consider that and are indeed working on that.

The other point I would like to make, of course, is that without the sharing of information within the health system—anonymized, as you mentioned—we would not be able to have the work of places like the Institute for Clinical Evaluative Sciences, ICES, which as you know has done some remarkably good work in helping hospitals be able to figure out what it is they're doing in what areas and regions of the province. We wouldn't be able to have that kind of good research in the system without some appropriate sharing of information.

If the ministry is to restructure the system—and you mentioned that the minister has talked about steering, not rowing. The only way one can steer and not row is to be able to give appropriate direction. We've heard from many communities and many hospitals that they want the ministry to be able to make some difficult decisions within their local communities. My region, is one where we went through a local restructuring exercise, but then we needed the ministry to make some decisions and to get on with helping the community restructure. We have heard that message from many areas.

With the appropriate safeguards which you've mentioned—we've talked about sunseting, we've talked about changing the minister's ability to influence hospital

bylaws so that the bylaw power of hospitals is allowed to be there—with those appropriate safeguards, do you see areas where communities do need the ability of the ministry to make some decisions, as long as that local consultation is there, as it currently is? There's nothing in Bill 26 that changes that. As long as that is there, is there some way for the ministry to be able to make some of these decisions and get on with the job of restructuring, which the hospital community has told us is very, very urgent?

Mr Rosenbaum: I'll answer that. I think the difficulty first is that there may be some communities in which hospitals will be unwilling to act without there being intense pressure brought to bear. We recognize that. We don't believe this is one of those communities. In fact, we've had a long history of collaborative relationships, one in which we have voluntarily transferred programs and budgets between our institutions in order to rationalize services as much as possible. Nevertheless, we recognize that this is not universally the case.

The problem is that the bill allows for forced changes in programs without the need that there be consultation, and ultimately there's no accountability, or there need not necessarily be accountability. The minister really must stand behind the decision which is made to amalgamate a hospital. Accountability can only be assured through the electoral process, and a commissioner stands outside that process.

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So I think there are those two changes which we see as essential to this bill. The first is that hospitals be given an opportunity to comment before the recommendations are implemented, and secondly, where there are major changes, that the minister acknowledge and accept those recommendations, that they not be implemented by a commissioner.

Mrs Lyn McLeod (Fort William): I appreciate your very thorough underscoring of the concerns of the Ontario Hospital Association, in fact the unanimous concerns of everybody except Conservative government members, about the unprecedented and unilateral powers granted to the Minister of Health under this bill. I believe that those concerns are increased by the fact that this bill is all about cutting dollars out of the health care system. It is a finance bill presented by the Minister of Finance on the same day that the Minister of Finance took \$1.3 billion out of hospital budgets and about \$1.5 billion out of the budget of the Ministry of Health. This is a bill that essentially makes the Minister of Health subservient to the Minister of Finance. I am deeply concerned that as the powers under this bill are exercised, there's going to be a lot more concern with cuts than there is with community, and that's why I believe people are worried.

I would like, however, to ask you to comment today on some powers in the bill in a section that you haven't commented on, recognizing the varied expertise of the people who are here. As you'll be aware, there are powers under this bill which allow the government for the first time to prescribe what is medically necessary and set the terms and conditions under which care can be provided to patients. It also provides the government with the power to deny payment to physicians for care that has

already been provided if it's seen to be not medically necessary, and in fact to force physicians to compensate the government for the cost of referrals if referrals were found to be not medically necessary. I wonder if you could comment on what you think that might mean to patient care.

Dr Marshall: While recognizing the necessity for the province to put its fiscal affairs in order and recognizing that health care, along with other sectors of the public purse, must make a contribution to that, and my profession is part of that sector, the powers that the government potentially takes upon itself, and in fact takes upon itself in this bill, allow it to intrude in a pre-emptive way into the relationship between a physician and their patient in a way that pre hoc, not post hoc, may well affect decisions in patient care.

While one does not necessarily anticipate the use of that power, and while one can understand at the end where that power might be used and directed in an extreme circumstance, the very existence of that power causes the relationship and the decision-making of physicians to be made under a particular threat.

To say that in a particular instance that will affect an individual physician's decision is probably not true. But individual decisions are made in a climate, and that climate will gradually change. I think this threat, even if not used, has a potential of having an effect on the way patient care is delivered.

Mr Marchese: Thank you all for a very thoughtful presentation. I want to highlight something that you said that I have observed in the House in the last short while. We were dealing with employment equity in the last couple of months, which has been repealed rather quickly by this government. Mr Clement is here, and in fact he said that bill was very "intrusive"; he used that word. He in fact even said it was very "draconian," and used other words as well, which I'll refrain from saying.

The point is that what you've done today that I've identified is the contradiction between what they say and what they do. On the one hand, they will say: "Employment equity was very draconian. We've got to get rid of the Advocacy Act because it's too intrusive." On the other hand, they introduce a bill, Bill 26, which in effect does that. It's very intrusive, is very draconian, and they find ways to justify it and justify why it is that they must get rid of something that's intrusive in other areas.

Do some of you have a sense of why it is that they can contradict themselves in this way, why it is that they need these draconian powers? Is it really for health-related reasons?

Anyone? Be gentle now. If not, I'll move on to another question. If you think it's too political, I'll move on.

You've made a number of recommendations that I think go beyond simply changing a word or two and then we fix Bill 26. I think if we implemented your recommendations, it would fundamentally alter Bill 26 and I'm not sure they would do that. But I really believe that a lot of what you say needs to be reflected on. I'm not sure quite sure that we're giving enough time to the Conservative members and the policy people who draft these things to consider these amendments in a very thoughtful way. Do you think that they will have enough time to

implement some of these changes? Do you believe that we need more consultation or more time in order to be able to give the public and the Conservative members time to be able to properly deal with some of the suggestions that you and others have made?

Mr Rosenbaum: You've invited a question. I'd like to answer a slightly different question and say that we've made it clear that we believe the bill can be improved by amendment. How much time is required I wouldn't speculate. I think the government has at its disposal experts within the various ministries who could address those problems.

I note, for example, Ms Ecker's remarks with regard to confidentiality. Her confidence that the confidentiality of patients will continue to be protected, I think, is a matter of interpretation, looking at the legislation. In that case, it may be a simple modification which is required, making clear that the release of a medical record to groups like ICES doesn't include the names of patients. That's a very simple amendment to the legislation.

As to how much time is required to address these, I don't know. As I say, I think the government has adequate resources to address them.

The Chair: Thank you, gentlemen, for your presentation. We appreciate your interest in our process.

Mrs McLeod: Mr Chairman, I have a question I would like to place on the record for the ministry staff to respond to. I'd like to place the question while there are people present who are involved in psychiatric care and expressed a concern for the confidentiality of records.

This is an issue which comes up on a regular basis. Yesterday in our hearings, Mr Chairman, you'll be aware that in response to a concern about access to records the government members provided an assurance that there was no need to be concerned about access to psychiatric records because the Mental Health Act would supersede the provisions in this bill.

It is our legal opinion, subsequent to that statement being made, that the Mental Health Act can only supersede this bill for patients who are resident in a psychiatric hospital; that for anybody being treated in an outpatient clinic or in a doctor's office, a psychiatrist or a general practitioner's office or in a general hospital, this bill would in fact have force and effect. I would like the ministry to respond and clarify that issue.

The Chair: Before the next presenters come forward, I do need to address something. The basic rules of the committee process are that the audience does not participate. Now I'm prepared to allow you to show your pleasure at the end of a presentation to somebody, but there may be somebody come forward who expresses an opinion you don't agree with. I wouldn't expect you to boo them. I would ask to—

Mr Alvin Curling (Scarborough North): Oh—

The Chair: Mr Curling, I'm in charge of this process, please. I would ask you to please either show your appreciation once at the end of the process or we will have to go by the strict rules of order and that is that there's no audience participation. I'd appreciate your support in that.

Interruption.

The Chair: We've got a couple of options here.

Interruption.

The Chair: Folks, we're in Kingston to listen to the concerns of the people of Kingston. We've got a couple of options. We're here till 1 o'clock. We can listen to people or we can recess the hearings. We've got a couple of choices.

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NORTH KINGSTON COMMUNITY HEALTH CENTRE

The Chair: The next group is the North Kingston Community Health Centre, represented by Tanya Beeler and Charlotte Rosenbaum. Good morning and welcome to our committee.

Ms Tanya Beeler: Good morning. I am here as president of the board of directors of the North Kingston Community Health Centre. With me is Charlotte Rosenbaum, the centre's executive director.

The North Kingston Community Health Centre is a primary health care facility which serves the residents in the northern part of the city of Kingston. This area includes a large senior population, as well as the highest number of children in the city. The community health centre was founded because community residents and health care professionals demonstrated to government the higher burden of illness in this area and the need for primary health services.

Community health centres are prime examples of organizations which are flexible and responsive to a variety of needs in the community. They are organizations which focus on individual and community strengths rather than weaknesses, and are fully accountable to the communities they serve and their funding bodies. They incorporate a team approach, effectively using a range of health professionals. All staff members working in community health centres, including physicians, are paid on salary.

We are proud of the many innovations in health service and health promotion in our community. Through intensive community work we have been able to develop programs and services which are needed by our community, and to move beyond the direct provision of services to the larger problems which affect people's health. We believe in fostering self-reliance and supporting individuals and communities to take responsibility for health solutions.

Volunteerism is the lifeblood of many organizations across Canada, and many volunteers contribute their time and energy at the community health centre. Most importantly, the community health centre is governed by a volunteer board of directors which provides a link between professionals, the local residents and ministry funders to ensure high quality, responsiveness and accountability.

The North Kingston Community Health Centre is a member of the Association of Ontario Health Centres and strongly endorses the submission made by that body to this committee. Without repeating too much of what has been already stated, we would like to respond from a local perspective to some of the provisions in Bill 26.

Before voicing our concerns, however, we would like to put them in the context of our general support for

reform of the health care system as stated in the Progressive Conservative document *Bringing Common Sense to Health Care* and in sections of the omnibus bill. In particular, we would like to express our support for the addressing of maldistribution of physician services; the rationalization and restructuring of the hospital system; alternatives to the fee-for-service system of physician remuneration; the emphasis on consumer and provider input; and the upholding of the principles of the Canada Health Act.

Indeed, our concerns in Bill 26 stem from areas where there seems, in our opinion, to be discrepancies between stated principles and new or amended legislation.

As we understand the bill, it provides for a range of facilities such as community health centres to be deemed as independent health facilities. It also allows for the minister's discretion to specify persons who may send in proposals for a licence to establish and operate an independent health facility. The bill eliminates priority to non-profit, Canadian-based health care services.

The high standards of quality of care set by Canadian non-profit health services should be the yardstick by which proposals are measured so that proposals professing initial cost savings are not translated into poorer quality or transfer of costs to consumers.

We are concerned that the proposed changes to the legislation will make it possible to narrow the selection process and eliminate fair opportunities to the public to tender for independent health facilities licences and that the principles of quality in our Canadian system may be undermined.

We are aware of the importance of swift and effective action to preserve the best of our health care system and eliminate waste and ineffectiveness. The government has committed to involvement of the public in health care decision-making and to creating opportunities for health professionals to provide innovative ideas from the front line.

Provisions in Bill 26 do not require such a process and make no allowances for input from either consumers or health professionals in key decision-making. Although we feel involvement of consumers and health professionals at all stages of planning is essential, the current bill does not even allow for a system of appeal once government decisions regarding hospital restructuring have been made.

We are concerned, along with our hospitals, about the proposed limitations put on boards of directors which could reduce their powers to make key decisions on a local level. These volunteer boards of directors represent a connection to health services and to government funders for the entire community. They engender a sense of caring and ownership for local institutions.

We are also fully aware that this sense of ownership can make restructuring and reform difficult at times, but we believe that communities which are given the opportunity to develop better local health care services can meet this challenge.

The Minister of Health currently has power to set health care policy and priorities, to fund or not to fund services and programs, to reduce budgets, veto hospital

bylaws and ensure that systems for accountability and management are in place.

We strongly support the minister's role in determining mandates and ensuring compliance in a time-efficient manner. Although grateful for this opportunity to comment on a bill with such far-reaching implications, we are opposed to lengthy consultations which can become battlegrounds for interest groups to maintain or increase their turf.

Our concern is the sweeping powers in the bill which allow the minister to act in the public interest without any guidelines as to how this may be determined and to transfer powers to an investigator who may assume all of the board of directors' authority and responsibility.

Ironically, our ability to participate in decisions about our own health care may have more of an effect on our health than the actual services we receive. Studies have shown that people who feel they have control over their lives and have a strong commitment and involvement in their communities have better health outcomes.

For these reasons, it is extremely important that the role of volunteerism and community input is not lost from our health care services. If extraordinary powers are needed for extraordinary times, people must fully understand the nature and purpose of these powers and at the very least have an appeal process available.

Primary health care typically involves primary prevention and secondary prevention. Primary prevention means taking measures to prevent an illness or condition before it occurs; for example, screening for diseases, immunization, healthy lifestyle practices. Secondary prevention involves the treatment of an illness or a condition once it has occurred to prevent it from getting worse. It may involve direct treatment such as medications coupled with lifestyle changes which improve health.

An example of secondary prevention in primary care is hypertension management. A person diagnosed with high blood pressure is at risk for coronary disease and stroke. A family physician or nurse practitioner can assist a patient to manage their hypertension effectively with proper medication, diet and exercise.

The savings achieved through primary care by the out-of-hospital management of thousands of patients and conditions has not been adequately measured. Yet the high risk for hospitalization for many people, particularly seniors, if these medications were not available, translates into much higher costs and unnecessary human suffering.

We are concerned that the proposed changes to the Ontario Drug Benefit Act which will require copayments from eligible persons "to bear some of the costs of receiving drug benefits" put undue hardship on many and may result in a false economy.

Seniors may have to choose between medications or proper nutrition, leading to irregular use of needed medications and unbalanced nutrition. Parents may choose to forego their own needed medications to ensure they will be able to cover costs for their children. Individuals with chronic conditions with significant drug costs may require more frequent use of institutions.

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In north Kingston, 96% of seniors have family incomes of less than \$20,000 per year and approximately two

thirds live in rental accommodations. A senior with a heart condition could be taking three medications on a regular basis. The combined deductible and dispensing fees would have a significant influence on annual income after costs of living are paid.

Seniors in this country are very proud and resilient. Many have lived through the Great Depression and a world war. It is our experience that they will do without before they will admit they can't afford something. A senior on a low fixed income and in poor health will be making compromises every single day on what is absolutely essential and what can be put off.

As representatives of a primary care organization, our job is to keep seniors like this as healthy as possible and avoid hospitalization. This added burden to seniors with low fixed incomes could make this task a lot more difficult to achieve. Maintaining individuals in the community through proper medications is a real economy which should not be overlooked or compromised.

We are also concerned that all drug products that are medically necessary and efficacious are listed as benefits and that price is not a determining factor for their inclusion. We also urge that if the bill makes changes to allow the minister to negotiate price directly with the manufacturers, the public is informed through a clearly stated process of the substance and basis for these decisions.

Primary health care focuses on the prevention and early detection of illness to prevent further damage. We fear patients will be reluctant to come for care and discuss problems such as substance abuse and sexually transmitted disease for fear of disclosure. They may fail to receive needed help before the condition becomes chronic and also poses a threat to public health.

We see patients as active participants in their health care, not as passive recipients. Health care providers enter into relationships with their patients which are built on trust and mutual respect.

Each of us in this room has entered into this type of relationship with a health professional. This relationship may have been positive and may have not been. But in each case, we enter into this relationship on the tacit understanding that the information we disclose shall be used for medical purposes only in the process of our care and treatment.

Each of us has shared information with a health care professional which we would be deeply concerned about being shared outside of medical necessity.

We are concerned that provisions in the bill allow for what appears to be the unrestricted disclosure and release of personal medical information if the minister or general manager deems it necessary for management of delivery of the health care system or "for any other purposes as may be prescribed."

Further, it allows the government to disclose personal information to any party it enters into agreement with. We are deeply concerned about the release of information on this basis without any protection for individual right to privacy.

These proposed changes, which so directly affect the individual's right to privacy, dignity and care without discrimination, seem in direct contradiction to the govern-

ment's commitment to a health care bill of rights and out of step with the spirit of the Common Sense Revolution.

We have highlighted a few of the concerns which were apparent to us from a local perspective. Although realizing the importance of haste in reform of the health care system, it is imperative that the principles set out by the government not be set aside for expediency's sake.

In light of the government's principles relating to fairness, public involvement in health care and protection of individual right to privacy, we recommend that government ensure that these principles are not compromised or undermined by any provisions in Bill 26.

We would like to be assured that the importance of the autonomy and accountability of board of directors is respected and maintained; that the need for public accountability and informed community input into health care decisions is recognized as essential and healthy; that the potential threat to individual privacy through unqualified release of individually identifiable medical information is eliminated; that medications remain accessible to those most vulnerable to disease and disability and that limited cost savings at one end of the health care spectrum do not translate into greater costs at the other end.

The board of the North Kingston Community Health Centre thanks the committee for giving us this opportunity to present our views and hope that they will be constructive.

Mr Frank Miclash (Kenora): Thank you very much for your presentation. I think we all know how important voluntarism is in the health care field. I'm looking for the impacts this bill will have on the quality of care that you, as an organization, provide to your patients or the people you serve. If you could expand a little bit on where certain aspects of the bill will affect that quality of care, I'd appreciate it.

Mrs Charlotte Rosenbaum: It's hard to say how directly it will affect it. As the previous speaker said, health care decisions and health care are provided in an atmosphere. If providers feel they are viewed as people who are working against the system rather than as part of the system, and if patients feel they don't have protection for the kinds of information they release, eventually it's going to erode that relationship. Particularly at the health care centre, we try very much to have patients become more active in their own health care, and I think some of the provisions in this bill will actually be a deterrent to that, that people will pull back.

Mrs McLeod: One of my frustrations with this bill is that it touches on so many areas and any one of them needs individual hearings so we can look at the impact of it. I appreciate your touching on a number of them including the access to information, and the irony that the copayment not only will be a penalty for those who have to pay it but they end up being more costly for the government rather than bringing in any real revenue. You touched on one that rarely comes up, and it's rather mysterious that the government wants to open new independent health care facilities without even a request for proposals.

I'm going to ask you just one very specific question on the whole idea of comprehensive health care, because that's what you're involved in in a community. Given the

past history, I think 1973, when there was a major de-institutionalization of psychiatric hospitals and we were supposed to provide community care, and we're still, 22 years later, trying to provide community care, are you concerned that cuts will be made to hospitals, that there will be a loss of hospital service in the restructuring process without the dollars being made available to the community? Do you feel that you need the reassurance, as a community, that the dollars that are saved will come back into the region and the community to be used for health care here?

Mrs Rosenblau: In all fairness to the present government, every other government has promised that and never delivered it. We're kind of hoping this government will.

Mr Marchese: Thank you for your presentation. I want to ask you a question in relation to what you said about your concern over long consultations and that this might give an opportunity to interest groups to take the process over. I'm more or less paraphrasing what you were saying. I'm concerned about that, because I view you as an interest group, as I do all the other presenters, and I think all these interest groups that are coming today, that would like to present today, are important interest groups in the process, because they all have something to say with respect to their respective disciplines. I don't see interest groups as a negative. I see interest groups as a positive thing and thank God they're here.

Did you have something in mind as to who these interest groups might be other than the people who are here?

Ms Beeler: It certainly wasn't my intention to imply that interest groups shouldn't be involved. Obviously we are here today. I think what there often tends to be—and I've been involved in various things like this—is when some people are allowed to speak and some people are not it almost forces interest groups to be somewhat territorial and it can be a divisive thing within the community.

Mr Marchese: Right. That's the point we're making with respect to who can speak and who cannot. If you don't give adequate time to people to be able to be properly consulted and to have a say, it could happen that those who are quick on the mark, who have a sense of what to do and what to say, will be the ones who will be heard as opposed to the others. So the point of it is to make sure that there's adequate time for everybody to be able to have a say, because all of us are affected by this bill.

Just to move on to another question, you talked about the issue of copayments, more commonly known as user fees, and you talked about the Ontario Drug Benefit Act and the changes to that and the effect it would have on seniors. Some seniors take not only three drugs potentially but up to 10, we're told by different users in the health field, so the expenditures can be great.

But if you take that in isolation of all the other user fees that are about to be imposed through the tools kit that this government has given the municipalities as they download, then municipalities will impose user fees, doctors and hospitals will do that, the independent health

facilities will do that, and then of course we have the drug plan.

If you take them all into account, that puts a greater burden on the seniors other than simply the point of user fees on the drugs. I'm assuming that if you take that into account, it will have a devastating on seniors in particular. Do you not agree?

Ms Beeler: Yes, added user fees will certainly have an impact on people, particularly seniors on low and fixed incomes. There's no question about that.

1030

Mr E.J. Douglas Rollins (Quinte): Thanks to you people for being here today. It's nice to see people like yourselves who do a lot of volunteerism and work with that. This government is certainly complimentary to people who do volunteer. You stated that past governments haven't followed through on their wishes and the hope that we can.

Interjection.

Mr Rollins: Well, there may be a change afoot, you know. Things have happened that way.

We are working under the Canada Health Act and we try to stay under that with some of the restructurings that have to go on. I know it's not an easy situation to be in. We have to be in position where we may have to make some decisions of closing some hospitals and things of that nature, and also putting some of those services back out into the community, out of the hospital.

I think with some of the things, like dialysis, that we're putting out into the communities, that are reinvesting those moneys that are being put out, those are the types of things that have to be followed up on and allow customers, you might say, or the people of Ontario the privilege of having that facility a little bit closer to them.

Regarding your copayment, we do realize that there is some concerns with people on low income, of that nature, and I think it does not fall completely on deaf ears. It is one of those kinds of things we have to take a look at. On the other hand, we have to be able, somehow or another, to reinvest our dollars in the health care system to make sure we get the best bang for our buck that we have. I think without exception, hearing many, many presentations, there's nobody who has come to the table, or who hasn't come to the table, and said it's completely right and perfect at the present time.

I don't perceive the things that we're going to do as being all right and perfect, but I do believe that it's a start in a direction that we can make some changes and make them for the better of not only people like yourselves but also everybody in the province of Ontario. I think that's one of the things we have to follow.

Licensing of these places: We certainly have to have the utmost of quality, top-notch, best-possible care for the people we represent. On behalf of the government, we can assure you that's the input we're going to make sure happens. Thanks for coming. We appreciate it.

The Chair: Thank you very much. We appreciate your presentation and your interest in our process.

Mr Mclash: Mr Chairman, we have had yet another amendment suggested. I would like to make a motion that at this time we ask that those amendments that have been referred to or suggested be tabled so that we can take a

look at them, so that we can move on in our hearings, knowing what the government has in mind. We just had a member of the Conservative Party suggest there was yet another amendment that we have yet to have access to, and I would certainly like the tabling of these amendments as we go along.

The Chair: Is that in the form of a motion?

Mr Miclash: Yes.

The Chair: Okay. We do have people waiting to make presentations. We didn't come here to argue among ourselves. We came to listen to the input from the people of Kingston. Can I have all-party consent to discuss this when the presentations are over? Everybody agree with that? Okay.

KINGSTON AIDS PROJECT

The Chair: The next presenters are Evelyn King and Paul Waltenberry of the Kingston AIDS Project. Welcome this morning to our committee.

Ms Evelyn King: Good morning. First I would like to thank the opposition parties for their stance against Bill 26 and advocating for public hearings.

Mr Miclash: Yes. Alvin.

Ms King: Yes, especially. I believe you prevented the ramming through of this undemocratic piece of legislation. We now have a democratic process which is unfamiliar to this government. It saddens me as a citizen of Ontario that these hearings were forced upon the Progressive Conservatives rather than being implemented by them. It reinforces my opinion that the Tories have declared war on the middle class, the poor, disabled and seniors of this province in order that the wealthy and business community can benefit.

During the election campaign Mike Harris made many promises. He provided hope for many when he promised to create 725,000 jobs. To date, we have only witnessed job losses. He also stated that he would not cut health care. This bill certainly invalidates that statement.

Hospital closures, staffing cutbacks and the emigration of doctors to other provinces or countries can only hurt the health care criteria of Ontario. The waiting lists for specialized tests and surgeries are currently too long. If so much money is taken out of the current structure of health care, how can it be more effective? The implementation of user fees will cause financial difficulties for seniors and the disabled. Most are on limited incomes and a vast majority must take multiple medications. Families with children will also be affected if there is a long-term illness or a disabled child. The new powers allocated to the municipalities through Bill 26 will also place an added expenditure on low-income Ontarians when user fees are implemented.

This government has been getting a lot of mileage from the statement, "We are spending \$1 million more an hour than we take in." This from a government that has not yet produced a budget. We all agree the deficit must be lowered, but I have a problem with the continual attack against the less fortunate of our society. It was not welfare recipients or users of social programs that created the debt. They do not live a profitable life, as suggested.

The real beneficiaries are the large corporations and the rich who have been subsidized for years through tax

deferrals and tax expenditures. A government should require our wealthy and business community to carry their fair share of the tax burden. I can only believe that this government has an agenda, and that is to create a tax-free business community at the expense of the low- and middle-class citizens of Ontario. There is a great deal of pain mushrooming through this province. I find it hard to fathom that the Tories cannot see or hear this. Why are there so many demonstrations and why is Queen's Park like a fortress? I have never seen Ontario in this state.

Another area of concern for me is the ministers in high-profile positions with no previous experience. How can critical decisions be made without consultation? You are dealing with the lives and livelihood of people, not commodities. A case in point is the decision to remove the rent-geared-to-income program. In order to maintain affordable housing, many seniors, disabled and families rely on this program.

How many people will become homeless because of this decision? Of course it is stated that something will replace it, but my confidence level is not high. With rent controls being eliminated, I envision landlords rubbing their hands in glee. The private sector will not provide affordable housing because they will not make a profit. In Kingston the vacancy rate is rising, yet the applications for subsidized non-profit and co-op housing grow daily.

I realize I have strayed from the health issue, but I believe these issues are all related. Good health is dependent on the security of employment and affordable housing.

Bill 26 opens the doors for all types of abuse by the government. This bill will allow access to my personal health records, which I really resent, and I'm sure others do in the province. Bill 26 will create a multi-tiered health care system in which only the rich are guaranteed full access. The Minister of Health is being granted too much power by this bill. Where in a democratic society does an elected politician warrant such dictatorial powers?

On these points alone my suggestion is to scrap Bill 26. The omnibus bill is a contradiction to the Tories' campaign promises and it will create havoc in Ontario.

1040

Mr Paul Waltenberry: My name is Paul Waltenberry, and I'm a community worker with the Kingston AIDS Project. When I was first asked by Evelyn to come before the committee, I contacted many service organizations across Ontario on what their reflection would be if this bill was passed. Here is one of the things they said: "If this bill is put forward and passed, it will have enormous repercussions for people living with HIV/AIDS in this province and especially for us in the Kingston area."

I would first like to address the issue of facility pay. Many of the individuals who are living with this disease cannot afford any type of group or private insurance. Furthermore, many people who are living with HIV/AIDS are on a disability and fixed income. Therefore, any further fees will force our consumers to live further below the standard they are forced to live with now.

Another section of Bill 26 will allow the minister to have unilateral powers over patients' files and the

collection and disclosure of information that is presently confidential. In Canada today there are approximately 70,000 individuals who are living with HIV and AIDS; 41% of that number live in Ontario. Those are individuals who have come forward to be tested. If this bill is passed, individuals who may suspect that they have been put at risk of contracting HIV will not, and I repeat "will not," come forward to be tested. There are reasons why. Please let me take a moment to explain.

Discrimination is one of the most feared forces that someone living with this virus experiences. People living with AIDS face an inordinate amount of discrimination directly or indirectly every day of their lives. Although it is illegal in Ontario to discriminate against people living with HIV/AIDS under the Human Rights Code, we hear and have witnessed stories of ignorance, fear, denial and hatred every day.

People have been denied such necessities as social and medical services, insurance, employment, children and family support because of their HIV status. If this bill is passed, then everything that AIDS service organizations across this province have been working towards will be non-existent. In Ontario today the availability of non-discriminatory medical services should be seen as a national shame, simply because someone has contracted an illness which is spreading faster than our ability and willingness to deal with it. This should never have happened, but our collective denial and active discrimination by this government have allowed such a situation to flourish.

If this bill is passed, it will allow the government to deny its collective agreement to protect the rights of every citizen of this province, including people living with HIV/AIDS. If this government refuses to protect the privacy and continues ahead with the power to access confidential files of patients and to disclose the information that is contained therein, it will have enormous repercussions. I urge you to protect the right to privacy for everyone in Ontario, especially everyone living with this terrible virus. You cannot allow this act to be passed in its present form.

Another area of concern is the government's right to delegate and authorize which patient is allowed to receive treatment or care for their illnesses. People living with AIDS face many opportunistic infections that are directly related to the virus. These infections and treatments are sometimes very costly, but some have been known to prolong or improve the quality of life for somebody who's living with HIV/AIDS for a period of time.

What right does this government have telling someone that they do not qualify for various medical services, not even being a doctor or having insight into the individual's illness? But based around the almighty dollar, this bill will deny the people of this province their basic human right to medical services.

In consultation with other AIDS service organizations across Ontario, we fear that if this bill is passed, discrimination will also play a large part in this government's decisions to approve or disapprove various treatments that may be costly and because PHAs, people living with HIV/AIDS, face discrimination at every turn, this bill will only reinforce that.

Many of our consumers fear that the impact of this legislation being passed by this present government will allow politicians to cater to a two-tiered system of health care, the individuals of this province who are able to afford high costs of treatment and people who are financially not able to afford treatment. Therefore, the quality of medical care that is supposed to be afforded to everyone in Ontario will no longer be available.

Services that are already insured are at risk of being eliminated by this bill. Many of the treatments and medications that are now available to people living with AIDS are still in the experimental stages. This bill will eliminate various services already insured through the Ontario drug benefit plan. Therefore, people living with AIDS, most of whom are on a fixed income, will not be able to afford these treatments and medical services. People will get sick and, not being able to afford the medical necessities of life, will die quickly. Passing this bill in its present form constitutes abuse and will enable this government to regulate who has the right to live or die. As an advocate for persons living with HIV and AIDS, I strongly urge this government to rethink its decision and regulate and control our health care system.

It has always been my understanding as a person living in a civilized and democratic society that regardless of which party is elected to lead this province and regardless of the individuals who chose to elect this party, this government is here to represent every citizen of Ontario and not a select few who can afford to be a part of this present government.

Mr Marchese: Thank you for your presentation. I want to refer to Mr McCaskell, who was from AIDS Action Now and made some interesting comments on the issue of privacy as well. He said:

"I think there are two levels to do with privacy. There's a level of principle, that people have the right to their privacy, and I think everybody understands that. But I think that the level we're dealing with here is something which I wouldn't say is more serious but is serious in a different way, because what we're talking about is what lengths people will go to to preserve their privacy and how that can affect public health.

"I know of people who were working, had an insurance program, and when they were diagnosed with AIDS and HIV bought their own drugs rather than put those drugs through their insurance program because they didn't want people in their office or even in the insurance company to know what they were suffering from since the drugs they had would be AIDS-specific."

And he goes on to talk about the implications of that. He says: "We know that once people test, their behaviour in terms of responsible activity changes dramatically. But people who think they may be infected but don't really know for sure can always talk themselves into not following safer sex guidelines."

Part of his concern with respect to having medical records made public in ways that we've never understood before has this potential danger for us all in terms of the lengths people will go to to protect their privacy. You said very much the same. Do you have any comment with respect to what Tim was saying?

Mr Waltenberry: Personally, from my experience, from the people we deal with and the consumers we deal with in our area—we serve a 100-mile catchment area here in Kingston—many of the people who get tested early and are HIV-positive tend to lead a life of not having sex. That's the bottom line.

If this bill is passed and the information is made public and the disclosure that people are living with AIDS is made public, people will tend not to go forward to get tested. Therefore, after a period of time they will continue with the exact kind of lifestyle they're already leading. This bill and this act will put other people at risk.

Mr Marchese: One of the things that we in opposition, and indeed the public, fear most is the tremendous powers this bill gives to cabinet, and the restructuring commissioner is another immediate example. What happens when we do that is, we make our politicians, or an agent who is given that power, unaccountable. If they have such powers, the point of it is, how do we make them accountable and under what process?

Part of what we did in opposition was to force the government, through the introduction of Bill 26, to be made accountable for the things that it is introducing. What we wanted is people to be able to say, "We want to know what's contained in this bill, we want access to that information and then we want to be able to respond to it." Do you think the people you've talked to have had enough time to review what's contained in this bill, to have a sense of how it might affect them, particularly or generally?

Mr Waltenberry: Not at all, and I'm sure that everybody who's come up here to speak and everybody who has not been given the chance to speak or address this committee or any other committee around this bill—one of the things that this government is doing is pushing this bill through so fast, and it is not releasing all the information to the general public so that people can respond to this bill, that when this bill is passed, the unilateral powers that this government and this minister will have will be catastrophic to the people whom this bill affects.

Mrs Helen Johns (Huron): Thank you for your presentation this morning. I'm sure it will come as no surprise to you that some of your premises I disagree with.

We believe we offered more hours of hearings than were eventually agreed upon by all the parties. We offered 360 hours, and 300 hours is what we are doing now, so we feel that we did try to get as many hours of public consultation as possible. We are listening to what people have to say, we have said that we will look at changes. I think this process is doing what we wanted it to do, what we all want to do as Ontarians, which is to make comments on a bill.

From my perspective, health care is the most important part of what we have in Ontario. We have guaranteed that \$17.4 billion will be in the health care system at the end of the four years of our government, but we never promised that the status quo would be maintained. I personally don't want the status quo to be maintained; I want the system to be made better. There is disease that is continually evolving; there's health care that we need to change to make it better and more effective for the

people of Ontario. The health care system has to meet the changing needs of the people of Ontario.

I don't think that's more obvious than in the field of AIDS. The minister has said that he has prioritized AIDS, both the commitment to AIDS resources and the financing of the search for a cure for AIDS. It's important to move funds from other areas to be able to work on new and important differences that are happening in the health care field. We believe that's what this bill is about: managing the health care so that we can bring it to areas such as AIDS.

With respect to the allocation of dollars, I think one of the most important areas for AIDS patients is that drugs are changing very quickly. In effect, the breath and livelihood of AIDS is new drugs coming out to find cures for your disease. In the past, governments have had to take drugs off the drug formulary to be able to add new ones that might be able to help AIDS patients, cancer patients, new diseases. If we don't change—

Interruption.

The Chair: Excuse me, Mrs Johns. We're either going to run this hearing with no participation from the audience or we're going to recess it. We've have four other groups we want to hear from—

Interruption.

The Chair: I'm sorry, the committee has been doing this the same way for six different cities; we'll do it the same way in Kingston.

Interruption.

The Chair: We're going to have a five-minute recess. *The committee recessed from 1054 to 1100.*

The Chair: If anybody's interested in the rest of the proceedings, we'll reconvene.

Mrs Johns: New technologies are being found for AIDS. In the past they've taken drugs off the drug formulary because there's been a finite set of resources. How do we continue to provide new technologies that are being found for AIDS patients with this finite set of resources we have if we don't make reallocations within the health care system?

Mr Waltenberry: Number one, what right does this government have to regulate a treatment that may improve the quality of life for somebody who has nothing to look forward to but death?

Mrs Johns: That's what we're trying to do by putting the drugs on the formulary.

Mr Waltenberry: But what you're trying to do and what this government is trying to do by passing this bill is to have unilateral power over the health care system in Ontario to regulate who gets treated and who doesn't.

Mrs Johns: I disagree with that.

Mr Gerretsen: First of all, I'd just like to respond very quickly. In the Common Sense Revolution it specifically states, heavily underlined in black, "No cuts to health care and no user fees for health care." To state that somehow at the end of the five-year period we're going to spend the same amount as we are right now, but that somehow in the middle there can be a trough in the funding for health care, is just intellectually dishonest.

What's really funnelling this whole thing is the tax cut. We're talking about a 30% tax cut. My question is very specific to you. The tax cut will amount to \$5 billion in

a couple of years, once it's implemented. We have a deficit problem in the province of Ontario and we have to cut out \$10 billion. With the tax cut we have to cut out \$15 billion, though. That means that the amount that has to be cut in the various areas is about twice as bad as it ever needed to be.

My question is this: Are any of the people you serve in one way or another going to benefit from a tax cut?

Ms King: Personally, I'm not. I live on \$11,000 a year. I know I'm not going to get anything from the government, and most people I know who are on low incomes will not benefit from a tax break. The only people it benefits is the rich.

Mr Curling: Let me say to you that I want to commend you for your presentation and the excellent presentations that I've heard here in Kingston. Listening to the government actually lecturing you instead of consulting with groups that are coming forward—as a matter of fact, this bill would have been law on December 14, and they're thanking you for coming forward and bringing amendments forward. We have to make sure that they don't ram this thing through and that democracy is alive and well, and we want to say thank you for making this kind of presentation.

Mr Wilson, the minister, said if you need drugs and you can't afford them, you must go and barter with the pharmacist. Do you feel this is an appropriate way for someone to conduct their life with respect to drugs?

Mr Waltenberry: Presently, every drug that somebody living with AIDS is on is in an experimental stage. There's a course of treatment that is outlined once somebody is diagnosed HIV-positive that is put forward by the attending physician. It should not lie in the hands of patients to go and barter for medication that could improve the quality of life that they need to live.

Mr Curling: The government has labelled people like yourselves special-interest groups.

Mr Waltenberry: You're damned right I'm a special-interest group, and with 70,000 people living in Canada who are infected with HIV and AIDS who have gone forward to get tested, and 41% of that number who live in Ontario, those are individuals who have opted to come forward and expose their status through getting tested. If our government refuses to protect the privacy and to protect the treatments that are afforded people living with AIDS, that number will quadruple and people will not come forward and they will be in a chronic stage of illness before they come forward to be treated, when they're put in hospital; then the cost of hospitalization will skyrocket; then this government will go forward and say, "Oh my God, what did we do?"

The Chair: Thank you very much for your presentation. We appreciate your interest in our process.

CANADIAN ASSOCIATION OF CHAIN DRUG STORES

The Chair: The next group is the Canadian Association of Chain Drug Stores, represented by Rochelle Stenzler, Sherry Porter, Syd Shrott and Terry Creighton. Good morning and welcome to our committee.

Ms Rochelle Stenzler: Good morning. The Canadian Association of Chain Drug Stores, CACDS, is pleased to

offer the committee its view on the implications of Bill 26 for the Ontario drug benefit program. My name is Rochelle Stenzler. I am the chairman of CACDS and in my day job the president of Pharma Plus Drugmart. With me today are Sherry Porter, president and CEO of CACDS; Syd Shrott, a CACDS board member and owner and vice-president of operations, Medical Pharmacies Ltd; and Terry Creighton, president of corporate relations, Shoppers Drug Mart, a member CACDS company.

CACDS represents traditional retail chain pharmacy as well as mass merchandisers and grocery chains with in-store dispensaries. A full list of our members is attached at the end of the presentation. In this province, our membership accounts for 836 stores employing approximately 16,000 Ontarians. Let me begin by saying that CACDS believes that the current system works well in providing drug coverage for all seniors and social assistance recipients in Ontario. However, CACDS understands the need for cost reductions and future controls within the Ontario drug benefit program. All partners in the delivery of drugs in Ontario—manufacturers, distributors, retailers, governments and patients—must share responsibility for controlling costs in order to deliver a sustainable drug benefit program which can maintain its widely recognized reputation for quality.

Bill 26 will make major changes to the Ontario drug benefit program. These changes fall into many areas. However, for purposes of today's presentation, I will focus primarily on two issues: copayments and deductibles, and pricing disclosure.

Today in Ontario, anyone who is over 65 or receiving social assistance or living in a long-term-care facility receives their prescription drugs free of charge. Currently, when an ODB patient presents a prescription in one of our member stores, the pharmacist fills the prescription and the patient does not pay. Instead, the pharmacist is reimbursed by the government through an electronic network.

The reimbursement is made up of two different components: first, the drug costs, which are regulated by the Ministry of Health. The reimbursed cost is equal to the best available price as determined by the Ministry of Health, plus an additional charge of up to 10% for distribution expenses. The second component is a professional fee of \$6.11. For this \$6.11 the services performed by the pharmacist and the pharmacy staff include the following: the actual dispensing of the drug, which includes repackaging and labelling; checking for drug and/or food interactions or reactions; checking dosage and/or day's supply; counselling on usage and side-effects; substituting generic products where appropriate; compliance checking for early, late or missed refills; and checking for double doctoring or polypharmacy where possible. In addition, the \$6.11 covers the pharmacist's overhead and operating costs.

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Bill 26 introduces patient cost-sharing into the system through a series of copayments and deductibles. Copayments will be made by two classes of patients. The first will be social assistance recipients, residents of nursing homes, single seniors with incomes of less than \$16,000 per year and families of seniors with less than \$24,000 per

year. These Ontarians will pay \$2 each on each prescription filled. The second class encompasses eligible single seniors with incomes of more than \$16,000 per year and eligible families with incomes of more than \$24,000 per year. This group will pay in full for the first \$100 worth of their prescription costs each year and then pay, as well, up to \$6.11 per prescription.

In the economic statement, the government's stated savings through these copayments and deductibles are \$225 million per year. Based on ODB data and our best estimates, this breaks down as follows: For social assistance recipients, those living in nursing homes and low-income seniors, the \$2 copayment will generate approximately \$46 million. For seniors over the income threshold, the \$100 deductible and the \$6.11 copayment will generate approximately \$179 million.

CACDS accepts the ministry's rationale for copayments. We understand and fully support the minister's intention to raise consumer awareness of the cost and the value of the benefit received and for the patient to share in some measure in the achievement of necessary cost savings. However, we are concerned about the structure of the copayments in Bill 26. Specifically, we wish to raise some very important questions about the \$6.11 copayment and the \$100 deductible for ODB-eligible Ontarians earning more than \$16,000 per year.

We are concerned because the amount of money those seniors must pay on average will be high—according to our calculations, in excess of \$230 per person, per annum. Moreover, there is no upper limit. Patients who have greater-than-average drug needs will be facing prescription costs into the hundreds of dollars. The ministry's own estimates indicate that at least 10% of seniors will pay \$412 per year or more for their prescription needs.

The ideal copayment program should build in disincentives against program overuse by patients, but without unfairly penalizing patients with high medication needs. The ODB's quality, fairness, equity and accessibility will be severely compromised under Bill 26.

We are worried about other aspects of this differential copayment and deductible system. When a patient presents a prescription, the electronic network will inform the pharmacist whether the patient is a \$2 person or \$6.11 person. I think you'll agree that this significantly compromises the patient's privacy, as well as creating a difficult situation, as pharmacists are forced to explain to patients, many of whom are elderly, why there is a differentiation.

Let's be clear about the administrative burden this will create. Maintaining running totals against a deductible is a complex business which no computer network performs anywhere near perfectly. When a consumer wishes to contest a private insurance network's tally, one has to fill out a paper claim, attach previous receipts and send it in for processing by hand. Is the ODB ready for this challenge? Are consumers? Does the government want to start maintaining digital and paper tallies for hundreds of thousands of ODB recipients?

As we said earlier, we accept the ministry's rationale for the patient cost-sharing concept. We believe that cost-sharing in general will be a deterrent to utilization. That

is why we recommend that the government make the \$2 copayment mandatory, so that all ODB recipients, regardless of income, take some responsibility for usage levels and the system's costs. The government of Alberta has taken this approach with a mandatory copay for all prescriptions.

We do not believe that the \$6.11 copayment and \$100 deductible for those earning more than \$16,000 is a sound initiative. As an alternative, we would therefore propose the following cost-sharing system, which will achieve or exceed the government's cost-saving targets.

As stated, we recommend a mandatory \$2 copayment on all ODB prescriptions filled. In addition, and this is our second key recommendation, for those earning more than the income threshold, we recommend a premium based insurance program instead of ODB coverage with a copay and a deductible.

The plan is simple. An eligible patient could purchase insurance at a flat annual rate and be enrolled in the ODB program. The system we're proposing is similar to purchasing dental insurance. Once the recipient pays the premium, he or she would be covered for all prescriptions and would make the \$2 copayment on each.

Our calculations indicate this premium would be approximately \$160 to \$180 annually or \$13 to \$15 per month. It should be noted that this figure is comparable to the ministry's own estimates that 50% of the seniors will pay approximately \$173 per year under Bill 26.

There is a similar program operating in New Brunswick today, although the funding mechanism is slightly different. It was successfully implemented in the summer of 1993 and has saved the government 37.5% of its previous drug program costs.

There are significant advantages to our suggested premium-based system over the \$100 deductible/\$6.11 copay program as proposed in Bill 26: It will make eligibility tracking easier and eliminate complicated billing disputes between ODB recipients and the government; it does not distinguish classes of patients at the cash register, so it doesn't raise any privacy issues; it is fairer and more equitable because it doesn't penalize patients with above-average medication needs; and for those who choose not to enrol, there is still a safety net against catastrophic need through the Trillium drug program, or they would have the ability to enrol at any time should the need arise.

Two other central cost control problems in ODB need to be addressed: overutilization and non-compliance. We commend the ministry for limiting in Bill 26 the quantities on prescriptions from 250 days to a new limit of 100 days' supply. Although this was done for economic reasons, it will prove to be of major benefit in improved health outcomes. We strongly urge the government to maintain this initiative.

On January 5, 1996, members of CACDS attended a meeting with ODB officials where our second major concern, pricing disclosure, was discussed. As you know, this issue is not specifically covered in Bill 26. None the less, we understand that consideration is being given to requiring the pharmacist to detail the cost components of any and all prescriptions, not just ODB ones. Currently, pharmacies are required to disclose on their receipts the

cost of the drug and the professional fee. Were such a measure to be adopted, all inputs of a prescription's cost, including the professional fee, any markup and the actual cost of the medication itself, would be detailed on the prescription receipt.

We are confused and surprised that this government would consider such a measure. There is at this time absolutely no product or service in Canada for which such disclosure is required. Are gas companies, which are provincially regulated, forced to detail the cost of exploration, production, transmission, distribution and maintenance on the bills they send to consumers? Are doctors, when billing OHIP, required to list the input costs of running their office, their staff, computers, supplies, medical training and undergraduate education on their claim?

On top of that, the pricing information would (a) be impossible to set an objective standard for, (b) be next to useless in making comparisons, and (c) be totally useless information for consumers, who are interested solely in the total prescription cost.

Does the government intend to carry this step to its logical conclusion, which is requiring that the input costs and markups of the drugs themselves be listed? We don't think so, which begs the question: Why would our input costs be disclosed on the receipt?

In Bill 26, the ministry has made a point of deregulating the private market. We find it amazing that this same government might in the same breath impose a significant, unfair and onerous regulatory burden on the same market it seeks to deregulate. Therefore, we recommend that there be no changes to the disclosure of pricing information on a prescription receipt.

In conclusion, members of the committee, we have before us a complex and challenging piece of legislation which deals in part with a complex and challenging issue—ODB reform. Let me sum up CACDS's position on the issues at hand:

We are in favour of a more cost-efficient drug benefit program.

We accept the ministry's rationale for patient cost-sharing and believe all parties in the delivery of drugs must share in it.

We understand and accept the rationale that the \$2 copayment which is in Bill 26 is limited to lower-income recipients, but we believe it should be made mandatory for all ODB prescriptions regardless of the patient's income.

We recommend that for ODB recipients with greater incomes, the government replace the \$100 deductible/\$6.11 copayment with a premium-based system, not unlike New Brunswick's.

We recommend that there be no changes to the disclosure of pricing information on a prescription receipt.

Together, working with all the partners in the pharmacy care system, we believe we can build a strong, sustainable ODB program for the Ontarians who need it.

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Mr Clement: Thank you for your presentation. It was very well-thought-out, from my perspective anyway.

I take comfort in your conditional support of the government's direction in this area, to try to inject some

accountability into the system rather than what we have right now, which not only is costing the taxpayers but there are also problems in terms of health care delivery. We've heard a number of deputants talk about the overprescribing that occurs with our seniors in our society. If there is a way to try to curtail that through some accountability in the system, is that something you're looking forward to as well?

Ms Sherry Porter: Yes, we are in a province that has a situation where the seniors are overprescribed compared to the other provinces in this country.

Mr Clement: You raised the issue of privacy, and you've got some very good suggestions on how to balance the need for some accountability with the privacy concerns, which is something that when one is in government one always has to grapple with. I'm not saying we've perfected it in our legislation.

To broaden the issue a bit further, because we've had some very emotional presentations already in Kingston this morning about confidentiality and privacy that—if I can say editorially, sometimes these generate more heat than light. My reading of the legislation, and I'm wondering whether you can comment on this, is that if you look at the deemed-to-disclose provisions found in schedule H—you may not be too familiar with them—a patient is deemed to disclose certain chunks of information about his or her record. That was in the old legislation as well. In the new legislation you're deemed to disclose, not generally, for whatever purpose, but for a set of four purposes in the legislation. My theory, and it's my personal opinion, is that that is more strict, more focused, less broad than the old legislation. If that is a correct interpretation, and if there is some way we can build in some specific curtailments to general disclosure, which I agree should not be the case and I don't think it is the case in the legislation—if we can further specify that and calibrate that, would that go some ways to alleviate your concerns?

Ms Stenzler: We recognize that you've introduced certain elements that you may believe will do that, but as a retailer let me describe for you what will happen in the real world. You will have two customers standing to pick up a prescription who are both ODB patients. The computer will tell the pharmacist that this is a \$2 person or a \$6.11 person; that's really what this boils down to. You will have them both standing at the cash register and you'll say, "Mrs Smith, your prescription is \$2," and she'll know that her friend next to her, Mrs Doe, is also a senior and she'll hear her being told, "Your prescription is \$6.11." You then have two elderly people saying, "Why am I different from her?" I think it's utter chaos. I've restricted it to two people standing there; you have hordes of people at a checkout sometimes.

Mrs McLeod: We've heard all week that Mr Clement keeps wanting to use his personal opinion to reassure himself that the law does not do what the law clearly does in terms of an invasion of privacy. The privacy commissioner has made it very clear that this act does in fact open new access to patient records, with the Ontario drug benefit plan administration of the copayment, with the independent health facilities and with access to records in physicians' offices.

I also find it amazing that Mr Clement can take comfort from a presentation that has said the copayment in this law is both unfair and unworkable. I appreciate the fact that this group has taken the time to present a potentially viable alternative. I don't know whether I would subscribe to it, but at least it's an alternative that has some greater potential for fairness, and it's exactly the reason this law should not be going ahead. This is the kind of issue that needs further consideration.

You did not touch on one issue I'd like you to address, and that's the whole question of deregulation. I'm almost a little hesitant to put it on the table; I see you groaning a bit. Ms Lankin and I shared a frustration yesterday in Ottawa because every presentation we've had has suggested something different about what deregulation will do to the price of drugs. We think, how can you just deregulate the price of drugs when nobody, least of all the government, has any idea what it will do to the price of drugs? We know at the very least that there may be a temporary increase; the Ministry of Health has said potentially 15% initially. We know the Minister of Health believes there will be different drug prices in different pharmacies and different communities. We've heard concern that chain pharmacies, for example, may be able to reduce the price of drugs because of the volume they do, but in small communities drug prices may be higher. We certainly don't think people who are sick or who have sick kids can go from pharmacy to pharmacy bartering for the best drug price. I, with some hesitation, ask you to comment.

Ms Porter: And with some hesitation we'll answer. You've mentioned many of the concerns we raised. We obviously would have liked to have addressed this issue, but when we tried to get information on what exactly was meant by the deregulation, we really weren't clear on what it did mean. Within our own membership we had varying reasons and results of what this could mean, and that was all based on the fact that we didn't have adequate input. We felt that if we didn't have the right information, we really shouldn't address it at all. We're hoping we do get clarification on this very soon.

Mrs McLeod: It's odd that the government, wanting to make this law, didn't have enough information, but I appreciate your hesitation.

Mr Marchese: I'm not sure I agree necessarily with the position you take that we should simply have a charge of \$2 for everybody and that might be more fair to everyone. On the whole, I take the position that it's unfair to most, particularly those who have very little to begin with. We know from statistics that seniors are on the whole quite poor, so when you impose that fee you're not helping them any. I'm not sure seniors are the abusers with respect to drugs or whether the abuse lies somewhere else. To impose the fees, to impose the abuse, on those seniors I think is wrong.

When you add these fees to those seniors, and additional user fees this government will impose through this bill—municipalities will impose user fees, and many are looking forward to it, hospitals, doctors, independent health facilities and the drug plan—when you add it all up, we've got a problem. Some seniors will pay a hell of

a lot. I'm very concerned about that fee and other user fees. Does anyone have a comment?

Ms Terry Creighton: I think I could respond to that one. Clearly, we think the current system is the fairest and the best for everyone in Ontario because it's free, but we're responding to the fact that the government has made it extremely clear that it wants to impose some sort of cost-sharing system. We're saying that if you're going to design a cost-sharing system, you have to do so with a very delicate balance. On one hand you want to put deterrents in place so that the system won't be overused, and on the other hand you want to make sure that people who have really high medication needs, those who need the program the most, are not penalized because of that.

We're saying put a nominal copayment in place, make it mandatory across the board so you do get the benefit of driving down utilization, where seniors will participate in the decisions their doctors make on what they're prescribed, but on the other hand make it fairer so that people who really need the system get the benefits of it as well.

Mr Marchese: I appreciate the position you're taking vis-à-vis what this government is trying to do. On the whole, I just don't agree with them or the position you're advancing, although you're trying to moderate, I suspect, in your own way the effects it might have on some people.

Mr Clement talks about privacy. I'm not sure whether you might have a comment. I was reading through Hansard the other day, and he was saying that the old section is broader than the new section in terms of its scope. The privacy commissioner, including Dr Cavoukian, who was with them, talked about that particular part and said the following:

"What we should draw to your attention is that the previous legislation as well was very problematic from a privacy perspective. It is for that reason that the commissioner has met with the ministers of Health over time and recommended that specific privacy legislation for health care records be developed because of the problems with existing legislation. So it's not that you begin from a place that is satisfactory for the protection of medical records."

In other words, he was saying we had a problem in the past and this particular section is going to complicate it even more.

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Ms Porter: I don't think we're probably talking the same thing here. What we're really concerned with is the privacy of the patient within the dispensary, and I think it's a little bit of a different scenario.

The Chair: Thank you, folks. We appreciate your presentation and your interest in our process.

HASTINGS AND PRINCE EDWARD COUNCIL ON AGING

The Chair: Our next presenter is Dr Margaret Cahoon from the Hastings and Prince Edward Council on Aging. Good morning, doctor, and welcome to our committee.

Dr Margaret Cahoon: Honourable Chairman and members, on behalf of the Hastings and Prince Edward

Council on Aging, I thank you for providing us with the opportunity to share our views concerning Bill 26.

The Hastings and Prince Edward Council on Aging is a non-profit charitable organization by seniors for seniors. Its mandate is to enhance the quality of life of older adults in order that each person shall have the opportunity to achieve full potential both in enjoying life and contributing to it. The majority of the board of directors consists of seniors, to facilitate their full participation in policy and program decisions. To provide a close working relationship with the current needs of seniors, representatives of service agencies give tremendous support to the seniors. The structure, objectives and some of the major accomplishments are presented in appendix 1 in the copy which has just been handed out to you.

Of the total population of the two counties in 1991, 15% was 65 years or more, compared with 12% for the eastern Ontario region and the province as a whole. In fact, in Prince Edward county it's over 17%. This percentage is the second highest in Ontario to Victoria county. Close to 25% of the population of the two counties are over 55 years of age. Both counties attract people who are retired or planning to retire. Most property sells to "move-ins" or "move-backs." Since both counties are major tourist areas, summer visitors increase the population and place heavy pressures on emergency and health services.

Many of our seniors lived through one if not two world wars and the Depression of the 1930s. They remember the widespread unemployment, poverty and homelessness of the Depression years, the devastation of critical illness and the almost total absence of economic security and care in old age. They were the generation that supported the development of comprehensive and universal government programs for health care, unemployment benefits, affordable education, pensions and the social safety network that has characterized Canada as a caring society, recognized as one of the best places in the world to live.

Seniors recognize the need for reducing the deficit and for economic reforms probably better than any other generational group. According to Revenue Canada statistics of April 26, 1995, four seniors out of every 10 are living on less than \$11,000 a year single, or slightly less than \$17,000 a year married. Seniors are among the first to acknowledge waste and inefficiencies in our health care services, and they want stricter control. There's probably no generation in our society as supportive of sound economic measures. Seniors had to pinch the pennies as they came up the years.

The next part is the concerns we have about the restructuring.

Some of the proposed changes in Bill 26 are threatening universal health care. It may be time to revise the Ministry of Health Act, as seniors are aware that governments change and Ministers of Health change. Can the proposed powers be trusted to this government and to its successors?

Bill 26 proposes the replacement of the Ontario Council of Health by a Health Services Restructuring Commission. What is its authority? What are the qualifications for membership? What are its functions? Is it assumed that restructuring will be an ongoing process?

With respect to hospital mergers and closures, many seniors and their families shared in the development and maintenance of small rural hospitals before there was any government support. They are still supportive, as evidenced by the foundation funds that have been developed for expansion and improvements. While seniors can understand the concept of merger with other hospitals in matters of purchasing at a better price based on quantity, they're shocked by the removal of the hospital kitchens and the provision of "airline" food in areas where there is an abundance of fresh foods. They can also understand the cost savings of laundry sharing, but are concerned about the loss of employment of kitchen and laundry staff workers in the rural areas. What other jobs are there for them?

Seniors can accept reduction in the administrative areas of their local hospitals, but they want protection of those who provide direct care. They want and expect qualified staff rather than replacement by technologists and technicians. They do not expect their local hospital to provide levels of specialty care, and they count on transfer to more sophisticated health care centres, such as in Kingston, but they recognize that much of the family health care can be provided in the local hospital. Seniors, when ill, want to be in their local hospital, where they can be visited by family and friends.

The proposed distance between hospitals of 40-odd kilometres is unrealistic. The distance of the catchment area is the only sensible consideration. Moreover, the road conditions, the weather conditions and other factors have to be considered.

According to the Ontario Hospital Association, only 7% of hospital expenditures goes to the small rural hospitals.

One of the major concerns at the moment is what will happen to the foundation funds that have been accumulated in the case of merger or closure. You won't find it's given over to the government very easily.

With respect to medical services, Bill 26 seems to be declaring war on the medical profession. The proposed legislation threatens the ability of physicians to provide care by setting fees for services, paying variable rates for the same services, and ordering repayments by the doctor for services considered retrospectively to be unnecessary. The power to decide which doctors can have hospital appointments and to revoke their privileges without recourse or compensation is almost unbelievable. I should point out at this point that I am not a physician, but I have worked with them for over 50 years. Similarly, the decision as to where one can practise is unrealistic. The Ministry of Health might recall the experiences of the theological colleges when they sent new graduates to underserved areas for a two-year period and found that they left on the exact anniversary.

Seniors have great loyalty to their family physicians. They are disturbed by the implication that doctors are cheating OHIP. They can accept that there may be a very few who are greedy, but they resent the idea that government control of all of them is necessary.

In some areas in Hastings county, there are family physicians who do not have hospital appointments. This situation results in double doctoring, as patients have to

be referred to a physician with such privileges in a hospital if they need hospitalization. It's difficult in both counties for the move-in or the move-back to find a family physician. Undoubtedly, this is one factor in the abuse of emergency departments. In some areas, there is already a reduction of services. Some practitioners want to take on only young families. Unless some compromises with the medical profession can be achieved, there will be a greater exodus of physicians from Ontario and greater difficulty in accessing quality medical services. Health care services are in very large degree dependent upon medical services.

With respect to the confidentiality of medical records, the proposed amendment to the Health Insurance Act and the Health Care Accessibility Act will give the Minister of Health or an appointed inspector power to go into any health care facility and examine, copy, remove and disclose confidential records. Although the Minister of Health has assured us that this amendment will be changed, what protection will be provided for the security of personal, private records? If seniors fear that their records cannot be secured, they may withhold information which could be critical for their care. Physicians may also feel threatened by the intrusion into privacy and confidentiality of communications with patients. Records may be edited to prevent leaks of vital information. Are there not more ethical means of achieving the information that's required? To whom do these medical records belong? Would confidentiality be better controlled if they were the property of the patient and/or family, as they are in some other provinces?

1140

With respect to copayments, "no user fees" has been replaced by "copayments." Is the difference inherent in the amount that can be shifted to the consumer? Are there plans for a two-tier system of care such as that in Alberta, which is being penalized for contravening the Canada Health Act? Changes in schedule F, Health Services Restructuring, make it easier to charge facility fees.

We have just heard the details about the amendments to the Ontario Drug Benefit Act. I was on the reform circuit three or four years ago, and I think we should be reminded that Ontario's seniors use 5.7 prescription drugs and 3.2 over-the-counter medications per day, a total of 8.9 medications, according to the Lowy report. If you count that up times \$2 in addition to the \$100—I'm not going to repeat all that was said in the previous presentation, but it's written here in this text. It's absolutely ridiculous to suggest that seniors shop for lower prices. If they're ill, they do well to get to a drugstore, if there is one available.

Just a couple of weeks ago I heard at the counter in my local drugstore a conversation about the Trillium drug plan that revealed income, and I was quite disturbed about it. One thing the ministry should do is make space accessible to the druggist to talk to the patient confidentially, because it was very clear to me, and to everybody who was shopping in that little drugstore, what the situation was. I don't think it's fair; we don't want a we-and-them situation.

I started in the health field before there was any of our present structure, and I saw how pitiful the situation was and how desperate it was. When I first went into community health, I did everything but steal to get enough to help mothers meet the needs of their children. If it hadn't been for the Red Cross, the Salvation Army and the Catholic Women's League, I don't know how people would have managed in the latter days of the war.

The drug program secretariat studied the use of user fees extensively, about four years ago probably, but concluded that the cost of collection might outweigh any savings and that it could bankrupt the small, independent pharmacies on which many clients depend. The presentations from some of the small pharmacies were really very shaking. I was disturbed by it when they told what the situation was in keeping the shop open.

It must not be forgotten that very large numbers of drugs and pharmaceuticals have already been delisted from coverage under the drug benefit program. Seniors are already having to pay for essential medications such as asthma drugs and calcium supplements. When we talk about \$2 a prescription, what if a family has four or five children with asthma? The cost of the inhalers and the drugs, times \$2—they're not all going to get them. It's only the worst that are going to be filled. When I started in community health, people were collecting prescriptions they couldn't get filled, and the only way I got the urgent ones filled for them was to get a service club to pay for them. We can't go back to that.

Bill 26 allows for the deregulation of drug prices, and I agree with the former speakers that I don't think we know what this means. The prices may skyrocket.

With the implementation of these copayments, will seniors be forced to choose between medications and food or other essentials? We have had reports just recently of some of the seniors buying cat food again, that don't have a cat. That happened 50 years ago. Do we want it to happen again?

Changes in the Health Insurance Act and the Health Care Accessibility Act mean that hospitals can charge user fees for anything not covered by the Canada Health Act that is not medically necessary. Patients on a waiting list for a nursing home or chronic care hospital may be charged about \$37 a day. What happens to the patients who cannot be transferred because of the required level of care? I ended my professional career as the Rosenstadt professor of health research at Sunnybrook Medical Centre, and we had patients who were there over a year, from the trauma unit, that no institution would accept. They didn't have \$37 a day to pay anybody. North York hospital was in the same situation. And we're closing hospital beds?

Again I ask, will the implementation of copayments incur more for cost than you're going to save? Saskatchewan introduced user fees in 1968 but found there was no reduction in health costs. With regard to privatization, it appears the government is advocating privatization of ownership and delivery of health care services. There's no evidence that privatization will do anything other than make profit for the owners.

The government may believe that services could be acquired more cheaply, but what about quality? To make

a profit, the owners have to reduce to the minimum. Are Ontario seniors ready to accept lower standards of care? Privatization really means Americanization of our health care services, and they can't handle their own.

There's a critical issue inherent in the proposed expansion of the renal dialysis program in this province which I'd like to commend very highly, but every member of the Legislature and every member of the Ministry of Health should read the article by Kirk Eichenwald entitled *Death and Deficiency in Kidney Treatment*, in the *New York Times* of December 4, 1995. I'll just quote a bit of it:

"Two hours into the medical treatment that was cleansing her blood, Sue Ellen Coffin screamed, pulled at her hair and vomited.

"Pandemonium spread at the Albuquerque Kidney Center as Mrs Coffin's screams were followed by those of five other people in intense, unexpected pain. The nurses on duty shut off kidney dialysis machines.... Most of the patients recovered but Mrs Coffin died within six hours.

"The terrifying episode 15 months ago was attributed to human error: A technician had thrown a switch to rinse the dialysis machines while patients were hooked up to them. The rinse, rather than the appropriate blood-cleansing solution, had been sent into their bloodstreams, causing a breakdown...."

Government investigations revealed actions by the company, the largest in the States, National Medicare, that led to the deficient care:

- Shifting the duties of doctors and registered nurses to lesser-trained and poorly supervised technicians and medical staff.

- Allowing the use of outdated, poorly maintained equipment.

- Manufacturing equipment that has not met federal standards.

- Keeping patients on dialysis for too little time.

- Re-using disposable equipment that manufacturers, including for many years a division of National Medical itself, recommended be used only once.

- Deviating federal money that could be spent on patient care to enrich its doctors for little work and to finance other businesses.

We do not need expansion of renal dialysis by American firms. An excellent model has been developed by the Kingston General Hospital in a satellite in Belleville, Ontario, and I think when you're looking at that situation, it should be examined.

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Since the signing of NAFTA, American health care insurers, suppliers and management consultants are working hard to take control of the Canadian for-profit market. I'm not going to read all of pages 9 and 10, but point out the amount of money that is going out of Canada to these American firms. They haven't been able to demonstrate for at least 40 years that they could handle the situation in the States, and yet we're paying millions of dollars for them to plan the restructuring of our health care system and our social network.

What is the matter with us? All of our medical schools are in a position to have staff who are very competent

researchers. You can give far less money to them to help the restructuring than these people are charging. I'm thoroughly disgusted with this situation.

I did my doctorate at the University of Michigan and I learned a lot that was not on the curriculum, as well as some that was. Many of the people will tell you that the health care system in the States is steadily getting worse and that it's a political situation rather than a situation with respect to care.

Vigilance is also necessary with Canadian for-profit firms. Even these have proven embarrassing to previous and current governments. Few may remember the Brown escapade in homes for emotionally disturbed adolescents, but many may have seen The 5th Estate's recent program on the aversion therapy of brain-injured Ontarians, where the director and owner was a graduate in physical and health education, not in psychiatry or psychology.

It's important to provide care in this province, but quality care is the bottom line. With the numbers who have lost positions in restructuring, it should be possible to develop exceptionally good not-for-profit facilities. It's a myth to believe that not-for-profit is more expensive in the long run. Moreover, there's no incentive in for-profit firms to do the research that undergirds non-profit services.

With respect to the context, welfare recipients are being told to get help from their families. Intergenerational pressures may result in seniors trying to share with unemployed sons and daughters, their grandchildren and even their great-grandchildren. Adult children and grandchildren are having to return home to their parents. Other seniors have families living hundreds of miles away and they hesitate to alarm them even when there's desperate need.

The primarily agricultural nature of the areas, many of which are on marginal farm land, are consistent with expectations which were never very high. There are more unpaid real estate taxes in some of the communities than has ever been experienced in the past, and there are more places having to be sold by power of sale. One man who did income tax returns for seniors through Community Care last April reported that he had no idea that so many people could live on so little.

Lack of transportation in the rural areas of both counties is another related problem. The proposal to remove rent controls may mean that some of the seniors will have to move farther from their necessary services.

Seniors who have been hospitalized are being sent home sooner and sicker. I heard what the young doctor said yesterday in Ottawa and I thoroughly agree with him: We have to have continuity of care. Discharge on Friday may mean that there is no one to help the family until at least the following Tuesday. That's not good enough, particularly when some of them are going home almost the next day, if not that day.

I have a few commonsense suggestions. One of the first is to get rid of the extra numbers of health cards that we've got in this province. It's estimated that maybe there are 50% more than the population. How much of the wastage do you think is coming from that? There is experience in Quebec, for some period now, and there is a project in Alberta using a smart card. It would provide

information in emergency departments and in doctors' offices that could drastically reduce the number of tests and medications.

It would also give the emergency departments and doctors's offices help in reducing the pressures for medications by drug addicts. They would soon learn that they couldn't acquire their supply that way. It can control double-doctoring to a large extent. All of the seniors had an identification card during the Second World War and it didn't do us one bit of harm, and I suspect in fact that a smart card might be a real comfort to seniors in knowing that there was immediate information available.

Is it now time that the patient's medical records become the property of the patient and family rather than the physician or institution? With the mobility of people today, it may be advisable for the patient to accept responsibility, although copies could be held by the physician and the institutions most frequently used. But I lost many years of mine just through the death of a physician in Toronto recently.

Drug record books are now available for patients. These could be combined with a medical record book to be signed by the physician. Phone follow-up of visits by OHIP have been made to check on medical billings, but so often the delay is so great that people can't really remember whether they were there on a particular day. If a simple printout of the billing was given to the patient, there would be much better evidence. Moreover, awareness of the costs might make the patient think about the need for the visit.

The Ontario government should pressure the federal government to repeal Bill C-91, the drug patent legislation. This legislation is one of the major causes of increasing drug costs.

If it has not already been legislated in Ontario, and I'm not quite sure about this, it should become mandatory to dispense generic drugs, where available, unless there are exceptional circumstances which would prohibit these instead of the more expensive brand-name drugs.

The family physician study in Hastings and Prince Edward counties is an important base for finding out how doctors use their time and what activities are included in practice. This study by the Hastings and Prince Edward Counties District Health Council, in partnership with the department of family medicine at Queen's, is supported by the Ontario Medical Association and the Ontario College of Family Physicians. A preliminary report is expected by late spring.

The most cost-effective measure is health education. Often seniors do not understand what they're told. Many were raised in an era when you seldom asked questions of the doctor. Today, it's important that patients understand what is wrong and what to do about it. The pharmacists have begun to provide medication education through a variety of media, as well as counselling. Seniors would probably use physician visits and emergency departments less if they had more accurate and authoritative information. Most seniors have no idea that the cost of a visit to the emergency department is much greater than a visit to the physician's office. These are things that I'm sure would influence activity.

About 20% of hospital admissions of seniors are related to drug interactions. On December 27, 1995, the federal Minister of Health approved a New Horizons grant to the Hastings and Prince Edward Council on Aging of over \$50,000 for an educational project, Medication Risks of Rural Seniors. I won't read you all the objectives, but they're in this report.

Another pilot project of the Hastings and Prince Edward Council on Aging: This one I'm speaking of is cosponsored with the women's institutes of the area and with the United Senior Citizens of Ontario, Zone 18. This latter one—I'm running over time I realize—is entitled Healthy Living on Less and it's directed to the development of mutual support groups in a least eight communities in the two counties.

These will be consumer-driven groups to help people live on less in their communities. Some or all of these groups may result in a skills exchange in which people may volunteer to help those who need assistance in exchange for something the recipients can do for them. A long-range outcome will be the empowerment of the members of these groups—the sense of achievement, self-esteem and security. These groups should enhance inter-generational relationships as some of them will involve younger people in their activities. They're directed to helping people remain in their own homes as long as possible, which is what most of them want above almost anything else.

In closing, let us not forget that change has to involve people, and change too vast made too quickly breeds resentment and resistance. People have to be involved if they're to accept change. Remember that the five principles of the Canada Health Act must be maintained: universal coverage, accessibility, portability, comprehensive coverage, and non-profit public administration. Our seniors and their families expect services that uphold these criteria.

The Chair: Thank you for an excellent presentation. It was exactly 30 minutes long, so your command of the time was very good too. We appreciate your interest in our process.

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KINGSTON AND DISTRICT LABOUR COUNCIL

The Chair: Our next group is the Kingston and District Labour Council, represented by Charlie Stock, the president; Gavin Anderson; and Vince Maloney. Good afternoon and welcome to our committee.

Mr Charlie Stock: I'm president of the Kingston and District Labour Council. Joining me, as has been announced, are Gavin Anderson and Vince Maloney, members of the labour council. We'll be making comments around Bill 26. With that, I'll turn the microphone over to Gavin.

Mr Gavin Anderson: Good afternoon. I'd like to start by thanking again the members of the two opposition parties for fighting to create this slim opportunity for participation in our democratic process, particularly Mr Curling. It's important to acknowledge that were it not for his act of protest, Bill 26 would quite likely already be law, and without the 100-odd corrections and amend-

ments that apparently have already been considered and accepted.

I'd like to begin my actual presentation by sharing something that both my grandfathers taught me long ago, when common sense was much more than a hollow political slogan. Each of these honest, hardworking men, both now long-deceased but very much alive in my memory, made their living with their hands. Each kept a toolbox filled with chisels and measures, screwdrivers and dozens of other wondrous gadgets and utensils that fascinated me as a young boy. I'm proud to say that several of those tools now occupy my own toolbox and in my home I have several of the beautiful and durable products these two gentlemen created with those tools. What these two men taught me is that you can learn a lot about a person by the state of their toolbox.

Bill 26 has been referred to as Mike Harris's toolbox. It supposedly contains the tools he needs to carry out his agenda for Ontario. I have looked through this toolbox as best I can, and I find no builder's tools. There is nothing in this box that can be used to put anything together, nothing that measures with precision, nothing that can join or smooth, no glue, nails or fasteners of any sort. Mike Harris's toolbox contains nothing but sledgehammers and axes and crowbars. Bill 26 is the toolbox of a demolition man. The 200 pages of text and the 2,000 pages of addenda in the bill form a wrecking ball. It is clear that Mike Harris is intent on smashing that which people of real talent, of courage and vision, have put together over a period of generations, particularly in the health sector.

A case in point: I'm a social worker and family therapist at Beechgrove Children's Centre. Beechgrove is a children's mental health centre serving families across six counties of eastern Ontario, from Carleton Place to Trenton, from Cardinal to Bancroft. As a direct result of budget cuts to our agency, we have just been forced to close referrals to our behavioural paediatric program effective January 1, and in three months the program will be entirely shut down. Our BP program, as it is known, is the only service in our huge catchment area that assesses and treats children suffering from a combination of emotional and medical problems, problems like enuresis, encopresis and many of the learning disabilities, including attention deficit disorder and hyperactivity.

Next on the hit list are our residential facilities, two of the finest clinical programs of their type in the province. At Beechgrove, we wonder and we worry about how many of our young clients, none of them criminals, all of them in need of treatment, will be consigned to boot camps for want of appropriate clinical placements. Both the BP and residential programs have waiting lists. Most on those lists may now wait forever. Children and their families are suffering now. If these children are ever going to grow up to be contributing members of our society, they need help right now. Without help, they will not be able to work and be productive, they will not be able to raise their own children to be healthy or productive members of our communities. Cutting these programs to children is not common sense, it's nonsense.

In terms of Bill 26 and its impact on our health sector, I will not attempt a precise critique in the brief time

allowed today. The bill is too large for that, and by the sound of it, its authors are already admitting that much of it is flawed and will have to be reworked and rewritten. I have no way of knowing what the government side has already decided to scrap. The problem I will focus on is the bill's entire focus.

The process used to ram this thing through is the strategy of the bully: no valid consultation, no attempt to find common ground, no commitment to creating real solutions to complex problems by building on the strengths of one of the finest health care systems in the world. The biggest concern the Kingston and District Labour Council has relates to the enormous assignment of authority to the Minister of Health and various commissioners, especially in schedule F on the health services restructuring.

There is no concurrent assignment of accountability. Authority without accountability is a classic prescription for irresponsibility. Irresponsible government is not in anyone's interest, let alone those who rely on the system. This being the case, the Kingston and District Labour Council cannot offer suggestions or recommendations that will bring Bill 26 up to any acceptable standards. It is a massive, fundamentally flawed piece of legislation, abysmally drafted and abusively presented. The only thing to do with this wrecking ball of a bill is to melt it down and start over, this time forging a new set of tools, constructive tools designed to fix and repair rather than demolish and destroy.

My grandfather Darrah used to say that even a stopped clock was right twice a day. I spent a day reading this bill, and let me tell you, the sponsors of this bill cannot even make that claim.

Mr Vince Maloney: Mr Chairman and members of the committee, I have been retired for several years, but there does exist in Canada and in the United States an organization known as SOAR. That stands for Steelworkers Organization of Active Retirees. While I may be a little inactive, I have the privilege of being president of chapter 16. We have the potential in Kingston and Gananoque and Napanee, having had several plants represented by Steelworkers, to have an organization membership of well over 1,000, but we haven't attained that yet. The reason for SOAR's existence is to be vigilant and to be able to intervene on behalf of seniors when governments do something sleazy and sneaky like you fellows are doing right now.

You have in your possession a response to Bill 26 that was presented by the Ontario Coalition of Senior Citizens' Organizations on December 19. Our organization endorses that document completely. However, I wanted to introduce a few personal thoughts.

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What a difference. Before the previous government introduced changes in legislation, there were province-wide hearings with full encouragement for public input, both pro and con.

Winston Churchill, at the beginning of the Cold War, coined the term Iron Curtain. Later, Communist China introduced what became known as the Bamboo Curtain. Now in Ontario we have the Wooden or Board Fence Curtain. Whereas the previous government invited and

welcomed healthy discussion and debate, the present Tory gang attempted to impose the tyranny of a massive majority through the underhanded process—I had “slimy” there, but that might be unparliamentary so I won’t use it—of introducing Bill 26 in concert with the budget lockup, and further hoped that the public would be thinking of Christmas shopping and other everyday concerns and would not notice the dastardly deed until too late.

Only by the fact that the opposition parties created a knothole in that board fence, we’re now getting a very limited peek, and what we see we don’t like. As a senior who remembers the not-so-good old days before medicare, I remember my grandmother dying at home after a series of strokes, with no professional care of any kind and the doctor only coming to declare, “Yes, she’s in fact dead.” Likewise, my father passed away in 1948 at home—no medical plan and no money to pay hospital and doctor bills. My mother, who was two years younger, was accepted years before in Blue Cross, now Liberty Health. They had refused coverage to my father because he was two years older. One wonders what “liberty” is contained in this policy now of Liberty Health, formerly Blue Cross. It’s the same measure my father had. Their motto and all other private, for-profit plans should be “Profit from Misery.”

In my own experience, the doctor who had attended my birth at home was selling his practice in Odessa and approached me because he’d never been paid and wanted to get the account settled. I can make the unique claim that I paid for my own delivery after I was 21 years old.

Likewise, the collusion of the Liberal and Tory parties in passing the current drug patent legislation through the effective lobbying of Judy Erola, former national Minister of Health and Welfare under Trudeau, shows how the two old parties are all but handmaidens of big business. After all, where do they derive their financial contributions from? They are not about to bite the hand that feeds them.

Do any of the current government members recall the demise of the federal Tories? Don’t forget that the people who voted you in will have another vote, with the opportunity to give you as many seats in Ontario as the federal Tories presently enjoy. Grey Power will be there, along with our Geritol, unless we die from the lack of health care. In the meantime, I suggest you start looking for a job. You’re going to need it the day after the next election. The boys on Bay Street might offer you something, but they don’t usually reward losers. Thank you.

Mr Stock: Let me close by saying the Ontario government is displaying a very callous disregard and attitude towards the citizens of our community, and indeed the province, by denying a proper amount of time and consideration regarding Bill 26.

Bill 26 represents a clear and ongoing decision on the part of this government to exclude the possibility for public debate and consultation on essential value questions for the society we live in. The Kingston and District Labour Council requests the government to suspend the current time frame for Bill 26. We ask for the legislation to be placed into its component parts and that a proper amount of time and energy be given to an analysis and

impact study, along with public consultation. The government has recognized to a limited degree the massive size and diversity of the omnibus bill by splitting the committee into two segments, which are health and non-health.

At the opening this morning we heard there were going to be over 750 representations in regard to Bill 26 and that that should be an adequate and proper consultation process. I would suggest, for anybody in this room and for the members of the committee who are fully aware, around this table, that when you have a bill that’s over 200 pages thick, and you have a compendium of over 2,000 pages that goes with it, and you’re allowing 300 hours of public hearings, certainly isn’t proper. That doesn’t allow seven minutes per page to digest, let alone try to swallow.

When you turn around and mix the health act, your municipality act, the Highway Traffic Act and everything else that you’re doing here, and try to put it across as if that is proper input, we’re here to tell you that you’re wrong. We totally disagree, and there are a lot more people from our area and across this province who are on our side than I feel are on your side of this argument.

We join with the opposition in requesting the government to start over in regard to Bill 26. After all, the citizens of Ontario deserve fairness, not borderline democracy. Thank you very much.

Mr Gerretsen: Charlie, you missed a few other acts as well: The pension act, for example, is going to take about \$400 million away from people who have rightfully earned that; the Mining Act that’s in here; the natural resources act; the Corporations Tax Act; the Public Service Pension Act. This is a huge bill, as you’ve already stated.

The 360 hours, by the way, that we heard about earlier for public hearings were all to be in Toronto. There were three committees to sit at the same time, from 9 am until midnight. This is the best we could do. We could only get half a day here in Kingston. Yet, I’ve been in the hearings on the other side of the committee, the whole week all over the province, and I’ve never seen in any other city as many people as have come out here today. It just shows you that more hearings are needed.

If there’s one thing that I disagree with my friend Vince over here, it’s the fact that he’s no longer active. I would never say that about somebody who’s done as much for the community as you have in one way or another.

You and I know that at the municipal level what makes the process work is public consultation and public hearings. You’ve been allowed to make a presentation, we’re given four minutes to respond per caucus and this is regarded as consultation. I don’t regard it as consultation. What are your comments on that, Vince?

Mr Maloney: I think the fundamental tenet of any democracy is adequate two-way conversation—open disagreement, yes, but consensus and finally arriving at something that both can live with and that’s going to be better than what the situation was before. They tried to sneak this through before Christmas without any consultation. I think they deserve the “Heil” salute.

The Chair: I find that behaviour absolutely offensive, sir, and I will not tolerate any more of it.

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Mr Stock: Can I just interject, because my name was mentioned in the question too. Excuse me.

The Chair: To the government. Mr Rollins.

Mr Rollins: Thank you, gentlemen, for coming out with your ideas. I don't think this bill was put together in 330 hours. It may not be known to you how many ministers and how many of these people have met with other deputations before forming this legislation. This legislation wasn't formed by the wishes of Jim Wilson in a closed-door meeting. He had meetings with many community-involvement people who were partakers of this.

Mr Gerretsen: But they were all closed-door.

Mr Rollins: Now, come on. Like the business community he was involved with; he met with over 200 doctors in Hamilton. I know that for a fact. Those are the kinds of things, and he put together, with the recommendations of these people, that the system we've got is not working. We cannot afford to keep on going and paying the type of dollar that we are in our health care system and still be able to support, as people here with different groups wanted, some new money spent on the development of new drugs and put forth. We've got to make the savings within the system. It's not an endless bank. Some of you people, it's very nice to sit there and say—

Mr Anderson: What about the \$5 billion? If that's a question, I'll step in and answer: You've found \$5 billion to put back in the pockets of the most wealthy people in the province. That's a start. Does Doug Gilmour really need a quarter-of-a-million-dollar tax rebate? I look at the agency that I work for, with a budget of less than \$6 million. That's the tax saving you're giving the Toronto Blue Jays alone. So if you want the money, the money is there. Don't say that it's a question of not having the money. It's a question of priorities and commitment, and you've lost your commitment.

Mr Rollins: No, we have not.

Mr Anderson: You have no commitment to the emotional or physical health of the people of Ontario. You're quite satisfied that the most wealthy people can purchase that service. You don't care about the common people of Ontario.

Mr Rollins: Yes, we do care about the common people of Ontario.

Mr Anderson: Where's the evidence? Bill 26 speaks against that.

Mr Rollins: The evidence was on June 8, sir.

Mr Anderson: No. You cannot interpret June 8 as a mandate to take apart this province. You had no mandate to do that.

Mr Marchese: I apologize for missing part of the presentation. I went outside to support the people who are holding a vigil outside. I understand some of you didn't have an opportunity to answer one of the questions. So, Mr Stock, rather than asking a question, I'd like to give you the time to respond to a previous question that was asked to you and to the other speaker beside you, if you would like to make other comments.

Mr Stock: Thanks, Rosario. I was going to say to John and to the rest of the people, about one of the comments that was made, that this government has never seen this

type of reaction by the people here. I'd just like to tell the current government that you haven't seen anything yet. You may win the day, but by the time this is over you'll remember your trip to Kingston. You'll remember your tour of this province, because the people have good memories and the people are not going to tolerate. This is absolute nonsense and has nothing to do with common sense. As my colleague Gavin has said, there are other ways to do it. If you had open minds, instead of closed minds and mean practices, you'd be considering that in a better fashion.

Some of us have been around a long time, dealing with legislative hearings such as this. I have never, and nobody here who's been around this table has ever, seen anything like this. To insinuate that this is a fair process is absolute nonsense. If that isn't acceptable to you people, that's too bad. You'll take the results the next election. Thank you.

ONTARIO PUBLIC SERVICE EMPLOYEES UNION

The Chair: The next presenters are the Ontario Public Service Employees Union, represented by Mr Warren Thomas, a member of the OPSEU executive board. Welcome to our committee hearings.

Mr Warren Thomas: My name is Smokey Thomas. I work at Kingston Psychiatric Hospital as a psychiatric nursing assistant. I'm also an executive board member on the Ontario Public Service Employees Union. Our democratic union currently represents 105,000 members provincially—whom, by the way, the government's trying to force out on the streets—over 5,000 locally, and locally we have over 2,000 workers actually working in the health care sector.

Province-wide, 20,000 of our members work in the health sector in hospitals, community agencies, long-term-care facilities, public laboratories and as ambulance attendants. These people will certainly be profoundly affected by this bill.

OPSEU welcomes this opportunity to present our concerns about Bill 26, the Savings and Restructuring Act, 1995. I too would like to join in thanking the opposition parties, and in particular Mr Curling, for their dramatic actions in stalling the government. I believe it's a page right out of a labour movement, a good shop floor democratic action: "Down tools and stop the process."

As well, we appreciate that the opposition actions were born out of the same frustration and anger that we as citizens feel. Everyone who's had the opportunity to review this bill is frustrated, angry—furious, in fact—over the proposed changes and the actions of a deceitful government.

This government has shown blatant disrespect for the public and for democracy in assuming that they could ram this huge omnibus bill through. Simply put, they're moving too fast even for fascists. Their actions insult the intelligence of the Ontario public and are clearly worthy of contempt. I could rail on for two or three hours about this bill, but you have our written submission. I think I'd rather focus on the way forward as a community.

In your package you have two proposals. One is called option K. Option K, simply put, is a proposal from

OPSEU members and our union to create a greater Kingston public services task force strictly to look at provincial government services directly provided.

We propose membership from the business community, labour, political—all three levels of government—public sector, institutional CEOs, and—I know they get offended at this—interest groups on an as-needed basis.

We would see the membership on a central steering committee consisting of the president of the chamber of commerce and two other representatives from the business community chosen by the business community.

From labour I would suggest someone from the public sector, perhaps myself—I'm a board member with OPSEU—someone from the labour council—in my mind it would be Charlie—and a representative from the Public Service Alliance of Canada, the other large federal union in the area.

In my view, political representation is absolutely essential. It would not necessarily have to be the local MPs or MPPs in person at every meeting, but they could send a representative. I would see the mayor and reeves of the surrounding townships or their delegates as essential members as well.

It's been my experience that on an issue-by-issue basis, other groups should have representation on subcommittees depending on what is being looked at. For example, if we were to look at health care we could consider forming a subcommittee with representation from the district health council, hospitals, health sciences complex, medical faculty at Queen's, business and labour. A steering committee could mirror the current CFB task force with additional representation from business in the provincial level to round that body out.

This committee could be mandated to explore service sharing arrangements, program sharing arrangements, joint cost-saving arrangements, revenue-generating arrangements and improved efficiencies within the provincial public sector in the Kingston area. This committee would seek public input into its proposals. This committee would make recommendations to the appropriate level of government within one year of its establishment.

If as a community we're able to bring these groups together in a non-partisan forum, I believe we'll be able to establish Kingston as a desirable place for both the government and the private sector to locate in. I believe our future prosperity depends in large part on our ability to work together.

The second proposal is for community forums. The current Ontario government continues to impose severe budget and service cuts, it continues to ignore the democratic process and refuses to facilitate meaningful public debate, consultation and input. To correct this injustice, we would propose a series of town hall meetings to allow for a real public debate, consultation and input. I had suggested that these meetings be on Thursday evenings. They could be Saturday morning, Sunday afternoon, whatever works for everybody, but we would suggest that at least five town hall meetings be held.

We would suggest the following topics, and not necessarily in this order or all these topics, or the list

could be expanded: Bill 26, health care, education, social services, and the Ontario public service restructuring.

In our view it would be absolutely essential that our two area MPPs clear each Thursday evening for the five weeks or five meetings, whatever, to be panel members. That means where I live, in Frontenac-Addington, we'd actually have to be able to liaise Bill Vankoughnet, see him there and have him speak. OPSEU would be willing to sponsor these events.

We would not control that process; we would simply facilitate the venue, and we would suggest that a three-person committee arrange for the appropriate panel members and moderators. We would suggest that the committee consist of one staff person from Mr Gerretsen's office, one staff person from Mr Vankoughnet's office and one member of our local community agreeable to the parties. We have a lot of local community leaders who would be seen as non-partisan and would be seen as fair and just.

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We believe that these forums would provide our community with the opportunity to express concerns and, just as importantly, offer alternatives. Of equal importance, our political and community leaders would receive input that would allow for more compassionate and informed decision-making during these difficult times. I'm going on the assumption that all MPPs get to have a say in the House and get to be part of the political decision-making process. I would certainly be happy to discuss that at greater length with anyone interested.

That, Mr Carroll, is definitely a sincere offer. We have had many public forums in the Kingston area in the past, and I think the information that comes out and the level of cooperation it builds in this community in particular are very beneficial. With that I think I could probably sit. It's hard to top what Vince said, what Charlie said and what Gavin said, so even though it gives the Tories more time for questions, I'll turn it over for questions.

Mr Marchese: One of the comments that was made by one of the Conservative MPPs, Mrs Johns, was I believe, "This is the process we wanted." I'm not sure this is the process they wanted or what they want. What they wanted to do was to pass Bill 26 very quickly before December 14, and if it wasn't for the effort we made in opposition, that's what they would have had. They would have had no consultation whatsoever. This would bypass the normal processes of a democracy, where people have an understanding of what's being proposed, an opportunity to debate it and of course, based on that, get some changes to the proposed bill. This is not the process they wanted, for the benefit of those who are here. We forced this process on them and we're happy that you're here, along with all the other interest groups. I'm happy to say that I support interest groups because they all have something to say and there is something that we need to hear from all of them.

Another deputant, and I thought it was Dr Cahoon, said people have to be involved if they are to accept changes. That's a statement that I think everybody would support. How can anybody support any particular aspect of any bill without being involved in it? Do you have a comment on that?

Mr Thomas: Frankly, I couldn't agree more. In fact, the previous government, on bills that went through, sat without getting in a gabble, jumping up or calling a recess like crybabies. They sat, listened to criticism, took the input, and you could actually see where your input, if it was valid and legitimate, changed what would happen.

As a community, Kingston is in store for a massive cut; all three levels of government are going to cut back. It's going to create enormous unemployment; it's going to create enormous hardship; it's going to put more people, from where I work at the psychiatric hospital, living in untenable living conditions, more welfare people on the street.

If there is a meaningful opportunity for people to come out, at least get it off your chest and say what's on your mind. You might be able to avoid riots—what they call riots—those types of demonstrations. If you don't have that, unrest grows, and then if Harris ever comes back to town, God help him. God help him if he ever comes back here, but that's what happens.

So I couldn't agree more, Mr Marchese. You've got to have public input, and that's from everybody. Why is it that the average citizen is excluded? I got here by virtue of being an executive board member of my union. I'm really pleased that there were some community groups here and other groups. But I would agree wholeheartedly with the motion this morning: Break it up; have the extensive consultations. They don't need this stuff overnight. It's not about money, it's not about the deficit; it's about political expediency and a political agenda.

Mr Marchese: Let me ask you another related question, Warren. One of the things this government prides itself on is that they don't want to be intrusive, that they want to get out of the way and let the private sector do the job right and just let every agency do the job right. That's what they say. What they've taken upon themselves through this piece of legislation is they've given themselves tremendous powers to do what they want. What is it that they want, in your opinion? Why is it that they're giving themselves such powers and at the same time saying they want to get out of people's hair?

Mr Thomas: Okay, this is my personal opinion. I don't believe they're interested in re-election. I believe they're interested in moving a business agenda forward. They can't be interested in re-election.

Mr Marchese: I hope you're right.

Mr Thomas: What they're attempting to do, in my view, is pull back control to about four or five people. That's not democratic. I mean, democratic is defined as majority consent to minority rule, but how do you define a minority? It's not five people in this province; it's the House of elected representatives, everybody we send into that House to represent us.

I work for the provincial government. I deal with regional directors, deputy ministers, everything else. The deputy ministers know what's going on. From that level on down, everybody's in the dark. You tell me that's democracy, you tell me that somehow there is not some other kind of sinister agenda, and I won't believe you, because there is, in my view, a sinister agenda. American health care is coming to Canada.

I'll give you a couple of quick examples. They privatized the lab where I work. It now costs the taxpayers 35% more than it used to. Whenever you introduce the profit margin, costs go up. The last government did a detailed study of contracting out, and I think we're moving towards contracting a lot of stuff back in, taking it back into the public purse where it rightfully belongs.

Working people and unions have a lot of good ideas about how to save this government money. But try to get this particular government—the most offensive thing I find as a union representative is that right in their Common Sense Revolution they say that OPSEU has a lot of great ideas and they will work closely with us, but Mike Harris has yet to meet with the president of our union. Now, if you were the CEO of a large corporation that employed 65,000 people directly, and you're union, right, wouldn't you think at some juncture you'd meet with the union president?

Mr Marchese: At some point.

Mr Thomas: Exactly. They're making very provocative actions: training scabs over at OHIP downtown here in the event of a lockout or a strike. They're training scabs, and yet they sit at the bargaining table and say, "We'll honour the essential services agreements." They give out misinformation. In fact, in my opinion, they downright lie most of the time.

Mr Marchese: They wouldn't do that.

Mr Thomas: I think they're looking to dismantle government to the extent that it serves their business partners, and that's the large multinational corporations. Not small business, not medium business—it's the large multinationals that take all their money and invest it offshore. That is, I think, the real agenda here.

Mrs Ecker: Thank you, Mr Thomas, for coming forward. It's good to welcome you for your second opportunity at the hearing table. I won't ask you the same questions we asked you in Toronto when you were there.

I'd like to thank you for, one, putting forward an excellent suggestion about town hall meetings. I'm quite prepared, as an individual, to attend them. I know I speak on behalf of my colleagues, and many of us in the Legislature have continued during December and January to have town hall meetings.

As a matter of fact, I have a series of meetings tomorrow with members of my community to hear input. I know some of my colleagues are still continuing to door-knock on a regular basis to talk to people one on one about what we're doing and the need for restructuring. I certainly have no problems with continuing these kinds of dialogues with people, as we have since June 8 and as we will continue after, on this thing as well.

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The other thing, just in terms of some comments made about who got to be on the lists and everything, because there was an oversubscribing of individuals wanting to come forward, all three parties had an opportunity to make choices about who they would like to have on their list to come forward.

Interjection.

Mrs Ecker: Hey, I'll leave my opposition colleagues to claim that. Mr Thomas, actually what would be about the average salary of your membership?

Mr Thomas: In OPSEU? On average probably \$30,000, low \$30,000, \$31,000, \$32,000 range.

Mrs Ecker: About 66% of the population is about that income level, and I think it's worth noting that 66% of the population will benefit from a tax cut. I think that's an important measure to mention.

Mr Thomas: Is that a question?

Mrs Ecker: Well, it's a statement of fact, but you can respond certainly.

Mr Thomas: Nobody is going to like this response. Regrettably speaking, I think people might actually support that tax cut because we're going to need every damned penny we can get to cover off the user fees and everything else that you're stripping away. You may find working people saying, "It might be only \$100 a year but damn, I'm going to need it to put my kid in soccer, because the township just raised it, and my property taxes just went through the roof, so do I walk on the mortgage and lose all my equity?" You're forcing Ontarians to, perhaps unwittingly and unwantedly, subscribe to that tax cut. But personally I'm opposed to it.

How can you justify in any rational kind of mind that you're going to keep borrowing money to give a tax break and hope that it somehow gets pumped back into the economy?

Mrs Ecker: But we're not going to be doing that, sir, and one of the things I've heard from workers—

Mr Thomas: We are. How can you say that?

Interjection.

Mrs Ecker: Excuse me, Mr Gerretsen. One of the things that I've heard from many of the workers in my own riding is that they want a tax break. After 65 tax increases over the last 10 years they want, and I think they deserve, a tax break, because there are a lot of people who are working very hard out there over the last several years through two recessions to put food on the table for their kids and a roof over their heads, and I think those taxpayers deserve a break. I think they deserve a break.

Mr Thomas: Could I ask you a question then? Could you somehow explain to me—you made a promise of creating 725,000 jobs. In OPSEU alone you're going to eliminate 14,300 just out of the 65,000. The broader public service sector transfer payment agencies I think were given to understand—I don't know what—I guess a phenomenal 50,000 jobs. In Kingston alone, just in the OPS, Ontario public service—I get paid from corpay in Toronto—people like that that get paid, regional directors of council are saying it's 1,000 jobs. Excuse me, I won't be paying anything into the system when I'm gone. I'll be one of those people.

I can't understand how you can say to welfare people, "Get off welfare, get a job," and then say to the public sector: "To hell with you. You're the scapegoat. You're the whipping post. We're going to lay you off. Go on welfare." How can you say that? I have no shame in saying I want to work for a living—

Mrs Ecker: Mr Thomas, I'd like to answer that.

Mr Thomas: —none whatsoever.

Mr Clement: She'd like to answer that.

Mr Thomas: Sure. Go ahead. I'm curious.

Mrs Ecker: I agree that a good-paying and a decent job is what everybody wants for their family. But I would suggest that if government spending gave us all the jobs, we'd all have at least two. The difficulty is that some of these jobs are being paid for by borrowed money to foreign moneylenders. Quite frankly, I'd rather have the money going to my health care system than to foreign moneylenders.

Mr Thomas: If you're saying you're going to make all these cuts and put it to the deficit, Ontarians might actually swallow that. But you're not. You're still giving a tax break before you balance the books.

Mrs Ecker: I can only speak for my riding, but we had 16 all-candidates debates in my riding where we talked in great detail about where the money would go, what it would mean for the impact on cuts. We had lots of meetings and discussions about it, and the people—and I can only speak for my riding—chose the plan that we put forward. So that's what we told the people—

Mr Thomas: Can I ask you to do—

Mrs Ecker: Just a minute. That's what we told the people of Ontario we would do. We were elected to do that mandate, so that's what we are attempting to achieve here. We believe there should be a balanced budget so we can all stop paying \$1 million more an hour than what we spend.

Mr Thomas: Can I ask you to do something for me then? As one of your employees, as a citizen of this province—two things actually: Phone Bill Vankoughnet. Tell him he's going to sit on these panels. All right? Tell him that when the media calls him or a concerned constituent calls him, he'll actually call them back, and we will see him once in a while. All right? And before you say to me and my wife, who works for the government, "We're going to put you both out of work and you're going to lose everything you worked for"—because, guess what, I earn my money working for you. I earn my money.

Mrs Ecker: You don't work for us; you work for them.

Mr Thomas: No, you're my boss. The last government didn't get that either. You're my boss; you're the government in power. We negotiate with you. This government can never understand that.

Mrs Ecker: I have no further questions.

Mr Thomas: I don't negotiate with the taxpayers. I negotiate with you.

Mr Miclash: Thank you for your presentation. We've talked a lot about Bill 26 and the hearings that are going on today and the hearings that are going on across the province. Earlier, one of my Conservative colleagues alluded to the fact that there were groups that were actually consulted on the drafting of Bill 26. Were you, or do you know of any group that was consulted on the drafting of this piece of legislation?

Mr Thomas: I don't believe the labour movement as a whole was. I know OPSEU certainly wasn't and I know I certainly wasn't consulted. I've been at meetings of our membership of over 400 and 500 people; one had a couple of thousand. We ask the question, "Has anybody in this room even been phoned by one of those polling companies that say they have 50% in the polls?" No one

ever puts their hand up. We ask the question, "Has anybody ever been consulted?" Nobody puts their hand up.

We have a strange kind of situation in being a government employee; there's a thing called the joint cost savings committee which is sitting, which was struck under the social contract, and my only bitch about the social contract was, you can't legislate cooperation. Certainly we had our disagreements over process and everything else.

They're making the pretence of keeping this process alive. They say that 80% of the cuts are decided, but they won't tell anybody. They'll give it to one person in my union and make them sign a confidentiality agreement so they can't tell anybody. How does that benefit anybody? How does that benefit the 1,000 people in Kingston who probably will lose their jobs in terms of us going forward and saying: "Let's look for some real alternatives. Let's look for some cost savings. There are opportunities"? But they don't consult with anybody.

I asked the question the last time, "Name me one person, one group, one union you consulted with," and they couldn't answer it, if you remember that.

Mr Miclash: I've been asking the same question as we've travelled across the province and finding the answer to be exactly what you've told me. Mr Gerretsen.

Mr Gerretsen: First of all, the one thing that the Conservative members just don't get, and I've raised this matter at least a dozen times in the House, is that the tax cut—their own financial statement of November 29 clearly indicates that the debt of this province is going to go from \$95 billion to \$120 billion, according to their own figures, by the year 1999, which is roughly the amount of money that will be paid back in the tax cut.

If you just forgot about the tax cut and at least put it towards deficit reduction etc, we wouldn't have half the cuts we're talking about right now—that's number one—and at least we wouldn't—

Mr Thomas: Hear, hear.

Mr Gerretsen: As far as the savings that the tax cut will give, and this again is according to the Common Sense Revolution, not something I dreamt up, it's about \$425 for a person making \$25,000 and about 900-and-some-odd dollars for a person making \$50,000, but it's something like \$5,000 for a guy making over \$100,000.

For anybody to suggest that the rich, the well-off—and I include myself in that group—aren't going to get a better cut than somebody else is absolute nonsense. They don't know anything about how our taxation system works, which is basically a progressive system: the more you earn, the more you pay, and therefore if you cut it, you're going to get a bigger slice, a bigger cut.

Mrs Ecker: Don't forget the fair share levy on the health system, Mr Gerretsen.

Mr Gerretsen: It's very little. Look at your own figures.

Mr Thomas: You're too charitable, Mr Gerretsen. I'll say this—

Mr Gerretsen: I'm always charitable.

Mr Thomas: You could be a little more forthright with them.

Mr Gerretsen: I try to.

Mr Thomas: It's the old adage: the rich get richer, the poor get poorer. The middle class in Ontario, and particu-

larly in Kingston, quite frankly was produced in large part by the government. I came out the north end of town; I came out of not abject poverty, I wasn't as bad off as some people, but I got a decent government job. I'll tell you how I got that job. I had to shake this guy's hand and say, "My daddy's a Tory, my granddaddy was a Tory, and I'm a Tory and I'll always be a Tory." I lied. But that's how I got the job, John.

I've gone to educationals not sponsored by unions on all this financial stuff and what's really happening here, and it has got nothing to do with the deficit, nothing. It's got to do with making rich people richer. What is it, 1% of society controls 80% of the wealth in Canada. So who really benefits?

Mr Gerretsen: The other thing that the members of the committee ought to realize is that one out of every two wage packages in the Kingston area comes out of the broader public sector, and the cutbacks both federally—and I'll take the responsibility for that, as a party member—and provincially are going to mean the loss of—I try to be fair to everybody; I'm not perfect either; I'll be the first to admit it—it's going to cost this community over 1,800 jobs, as indicated in a Whig-Standard report just recently.

Kingston has always been a very stable community, but 1,800 jobs lost in this area is going to have a tremendous impact. You're talking about almost \$83-million cutbacks by various organizations and by various government levels etc. By the way, I think your idea of these town hall meetings is a great one. The CFB Kingston study in which you and management and the local community were greatly involved was a great push in that area, and I'll certainly play whatever role I can to make it happen in this area as well. I'll even speak to Bill Vankoughnet and ask him to come.

Mr Mario Sergio (Yorkview): I won't ask any questions. I have enjoyed very much the presentations this morning, every one of them. We do have Bill 26 now, and I wish we didn't have Bill 26 to deal with. But let me say that when Bill 26 was introduced in the House the Premier didn't know its content; Mr Eves, the Finance minister, didn't know its content; no minister knew the content of Bill 26 and, with all due respect, no other member of the House, that side or this side, because nobody had received the package. No one. So I can sympathize with everyone who has been attending presentations in various parts of our province, showing major concerns. We have heard from "drastic" to all kinds of other names that the bill has been called.

My problem with it is this: I'm saying to the members from the other side that when they get back to caucus in Toronto, they will have less than a week to absorb everything they have heard throughout the province. They will have a number of amendments, both from their side and this side here, and I just can't see ramming through an amended bill when no one fully understands the impact as it is now, with all the various amendments they will have to deal with, which means they want to push an amended bill, if you will.

I have to say there are good financial reasons why they want to push it through. It's not solely because of an ideology; I think there are big dollars attached to it. They

want to have this approved as quickly as possible, so they can put in place, implement some of the things they are saying they want to do, so they can raise some of the big money this government needs. There's a financial attachment to Bill 26.

My final comment is this: Most of the ministers didn't know when we posed questions in the House how to answer even for their own particular department. They absolutely did not know the content of the bill and they still don't because it's very complex.

Mr Thomas: My half-hour is not up, by the way; it's not 1 pm. I might make one comment on that. If they go back and a week later they ram through—first off, they shouldn't amend anything; they should just scrap it. Go back to the drawing board and start over—that's our official position—and engage in real and meaningful consultation with the people of Ontario. They did not get the mandate they claim to have when they got elected, and when they got elected they got elected to represent all citizens of Ontario. They're not doing that.

The Chair: Thank you very much, Mr Thomas.

Mr Thomas: Excuse me.

The Chair: The meeting is recessed.

Mr Thomas: Excuse me, Jack. Don't interrupt me again.

The Chair: The meeting is recessed until Peterborough.

The committee recessed at 1254 and resumed at 1701 in the Ramada Inn, Peterborough.

The Chair: Good evening, everyone. First of all, welcome to our committee hearings. We're happy to be here in Peterborough. I do want to throw in a plug here. This is my home city. Most of you here probably don't know me, but I was born and raised in Peterborough, and it's nice to be back home.

We've added the extra space. Unfortunately, the sound system isn't quite adequate, probably, to handle that extra space, so we're going to have to maybe be particularly quiet just so that we can hear.

We've got eight presenters, I believe, tonight. Because of the rules that the committee is operating under, rules that are set by the Legislature, we are not allowed to sit past 9 o'clock. We have eight presenters, a half an hour each, from 5 to 9. I would like them all to have their time, so we will go through this as expeditiously as possible. The dialogue is between the presenters and the people at the table. Any of the committee members would be happy to discuss anything with you, on a one-on-one basis, after we finish. I would hope we can get through this in a nice, friendly sort of way, because there certainly are different opinions available.

We have a motion that was presented in Kingston. Because of a couple of technical difficulties there, we didn't get around to dealing with it. It's a short motion. Can I get all-party agreement to just spend a minute, a quick statement on it and then call the vote so we don't impede on presenters' time? Okay. Mr Miclash.

Mr Miclash: What we've seen earlier today, as in the past, is that we have a good number of amendments that are going to be required in terms of this legislation. For people who are unfamiliar with amendments, they will come from all three parties, whether it be the governing

party, the NDP or ourselves, the Liberals. I guess what we're looking for and what I believe was a commitment of the minister was that some of the government amendments that are being worked on we would like to see tabled at the present time. Should we have those amendments in hand, we would know where portions of this bill will be going for further discussion, for further hearings. I just think it's a very important fact that if we could see the amendments that the government is going to table when the legislation goes back to clause-by-clause, it would make the process much easier.

Mr Marchese: I certainly support that motion. It would be very helpful, if they have a sense of what those amendments are, to present them to us, because then we would not be repeating the same questions to the presenters. The presenters would know in advance, because we would know and would let them know, so that they would be able to adapt those points they have and speak to other issues so that we wouldn't have to reiterate that.

I'm not sure they have amendments, other than alluding to the fact that they will make amendments. Perhaps that's the case. We simply argue in support of what Mr Miclash is saying, that if they have them, we would like to see them.

Mr Clement: I can confirm to Mr Miclash that we don't have any wording of any amendments to date. We're taking this process seriously. We want to hear from as many people as possible before we finalize amendments, so I don't want to short-circuit the process tabling what we think is the etched-in-stone version of the bill without hearing from, say, Peterborough or Windsor next week or what have you. I can assure the member that we don't have amendments that we've got in our back pocket. There are no amendments that have been worded. I think we all have our individual views perhaps, but they haven't been coalesced. I might add that the Liberal caucus in its press release this morning indicated that your amendments will not be ready until the first week of clause-by-clause, so I think that seems to be the trend on this committee.

The Chair: All those in favour of the motion? All those opposed? The motion is defeated.

You've just probably seen something very historical: three politicians actually speak for one minute each. I guarantee you, it won't happen again this evening.

PETERBOROUGH COMMUNITY PHYSICIANS

The Chair: The first group to present to us tonight is the Peterborough Community Physicians, represented by Dr Paul Leger. Welcome to our committee. You have a half-hour of our time to use as you see fit. Questions, should you allow time for them, would begin with the government and the question time would be shared evenly. The floor is yours, sir.

Dr Paul Leger: Mr Chair, I have a prepared document which I'd like to read from and guide my comments, and thus your questions, from that. I'd like to first of all thank the committee for allowing this opportunity to address the concerns that Peterborough Community Physicians has with regard to the effects that Bill 26 will have on quality of care and delivery of health care in this community and across the province.

There are five major areas of concern that I'd first like to address with regard to Bill 26: (1) Government violation of legal contracts represented in this legislation, (2) violation of the democratic principle of fair representation, (3) violation of patient confidentiality, (4) unfettered ministry involvement in health care management, and (5) concerns about who assumes responsibility for patient welfare and care. I'll elaborate on those.

Concern 1: Schedule I allows the government to unilaterally break legal contracts approved in legislation. Under schedule I, previously negotiated contracts with the Ontario Medical Association are designated. This means government's legal contractual commitments will not be fulfilled; physicians' obligations have been.

Concern 2: Patient confidentiality of personal information is violated in this bill. Under schedule H, part I, section 33, inspectors can enter any medical practice and review any patient file. Schedule H, part I, sections 2 and 21 allows publication of any personal information that the minister wishes. Schedule H, part I, section 21 states that when a person obtains an insured service, it means they automatically give consent to the release of personal information, and schedule H, part I, section 21 is the section whereby the government is not legally liable for the consequence of violation of patient confidentiality.

Concern 3: There is loss of fair process and the democratic principle of right to fair representation is violated. Schedule H, part I, section 6 states that appeals of ministry decisions, based on the discretionary criteria which I will elaborate on further below—when these decisions are made against the practitioner, they're to be reviewed by the Medical Review Committee, whose terms of reference and appointment are determined by the minister. Then under schedule H, part I, section 27, there can be no legal action for compensation for the result of these decisions. In other words, if the minister decides to take away a licence, change the services that a physician can provide, they will be removed and there is no recourse for the individual.

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Concern 4: The ministry is given complete power in schedule H, part I, to micromanage all aspects of physician services. I will enumerate these:

(a) There is unilateral determination of physician eligibility. Under section 26, the manager of OHIP can establish the eligibility of any practitioner by any prescribed criteria.

(b) In section 19, the minister can arbitrarily determine contributions or fees that practitioners or health facilities respectively would reimburse back to OHIP. The minister can, as well, set arbitrary thresholds under section 11 and everything billed above that is not paid. Again, these are arbitrary figures.

(c) In section 11, the minister can set a fee value at nil. I will review these concerns below.

(d) Differential fee schedules can be created which can vary from one practitioner to another and the ministry can determine what the appropriate and arbitrary criteria are.

(e) Where an established practitioner may practise could be determined by setting fees by any prescribed criteria if those criteria were based on geographic distribution.

(f) The ministry prescribes what constitutes an insured service, constitutes a necessary service or what proves the service provided equals the service billed.

(g) All the above concerns with regard to the discretionary and unilateral approach recur in schedule F in application to independent health facilities, and as the minister can designate any physician as such a facility, they would apply to the physician. This is under schedule F, part IV, section 20.

The increase of the control and involvement of government is counter to the stated goal of this government to decrease governmental load.

Concern 5: Physicians have always had the responsibility of patient management and outcome. However, under this bill the ministry will have total control to allocate service provision. Is the ministry prepared to take responsibility for patient outcome? In addition, physicians, who are the main advocates of quality care, can be completely removed from the management process in health care.

I'd like to go on to address effects on health care delivery. Patients will be reluctant to disclose personal information, and thus diagnosis and treatment will be compromised. For instance, 15% to 20% of people will have psychiatric illness in their lifetime. Physician access to full personal information is essential for proper treatment of all medical disorders, including psychiatric illness.

A threat of arbitrary bureaucratic evaluation on every service and a fear of uncontestable, punitive action, will lead away from a focus on provision of service and towards a focus to get prior authorization and to make minute documentation for every service performed. Decreased efficiency and productivity, delayed service provision and decreased service provision will result.

There will be significant problems as a result of unilateral ministry management for all service delivery. The prior experience of this community with regard to the underserved designation process, and the setting of a service at nil, serve as examples of how this unilateral and, I would say, uninformed—in the sense that physicians and not bureaucrats provide patient care—control will impact on health care.

Last year, this community applied to OHIP to be designated as an underserved area. We'd experienced several years of inability to attract enough family physicians to this area. We'd established a waiting list of some 3,000 to 5,000 people without a family physician. Our medical society did a census of active family physicians and found that the current population-to-physician ratio was approximately 1,700 to 1, which was within the criteria to be designated as underserved. The ministry determined by their figures that the ratio was 1,100 to 1, which is below the average expected for a family physician. The ministry would not release the information on how they arrived at this figure despite repeated requests. To this day, we are still underserved, with a large population that has no primary care physician. My office and many others get requests daily from people with no family physician requesting we take them on as patients and we are unable to comply.

With regard to setting a fee at nil, a lack of appreciation of consequence is evident. I'd remind you this is one of the provisions within the legislation. There are two

scenarios for setting a fee at nil. The first is if the service is currently not an insured service and is billed to the patient directly as a non-insured benefit. This is usually telephone advice or telephone prescription renewal. If this service was put in the fee schedule payable at nil, more office visits billed to the system will be the result as the patients would not get that service over the phone. This will cost the system more than what is currently in place, and the volume of additional service will not really be able to be accommodated.

The second scenario is that if a service is currently in the fee schedule it could be reduced to zero payment. If this service were, say, abortion, as there would be no payment for it, there would be decreased availability for this particular service. For any service rated at zero, it actually costs the physician or hospital to provide it about 50% of the current payment in overhead costs.

Likewise, if psychotherapy codes for family doctors were zero-rated, in communities like Peterborough where there is currently a shortage of psychiatric services there would be a crisis, as family physicians are providing the bulk of primary care for psychiatry in this community.

An inevitable consequence of all the above discussion is going to be extreme demoralization of physicians, as the ability to provide needed service is eroded in a system which will be perceived to be arbitrary and punitive towards physicians. One result will be a progressive exodus of new trainees, primary care providers and specialists out of the province. This community has already seen many physicians leave, with many patients left with no primary care physicians.

Potential solutions: Schedule I should be cancelled and meaningful and constructive negotiations with physicians entered to obtain workable and democratic solutions. Physicians wish to be part of the solution, not blamed for the problems.

If this legislation is to go forward, significant changes should be made to the arbitrary and unilateral powers the ministry would have. For instance, the ability of the ministry to set arbitrary fee schedules, fees or contributions payable back to the ministry and arbitrary thresholds should be deleted. Criteria for ministry standards to determine appropriate and necessary services, fee schedule variance and physician eligibility should either, at the minimum, be set by a panel equal in representation by physicians and government, or simply be deleted. An independent and objective appeal panel should be stipulated within the legislation. Physicians should be allowed the right to have legal recourse to the process in addition to an objective review panel.

The right to physician-patient confidentiality has to be protected. The power of inspectors to remove patient information from a place of storage and the right of the minister to publish personal information should be stricken.

One goal of this legislation was reputed to be cost saving in health care delivery. The size of the bureaucracy required to police and administer it alone would preclude this goal. The inefficiencies of bureaucratic micromanagement are going to increase cost and decrease service provision.

There are significant cost-saving issues not addressed in this bill, such as getting rid of the several million

fraudulent health care cards or adopting primary care service plans such as proposed by the Canadian College of Family Physicians, which provides incentives for both service providers and patients to be cost-effective. Information on primary care plans is available at the OMA, and the OMA awaits discussion on this issue.

Fundamentally, there are restrictions to cost cutting, and the system is already thin after five years of cuts—and there have been five years of cuts. Utilization increases are driven by increasing and expensive new diagnostic and treatment modalities, as well as increasing patient demand for service. The latter at least needs to be addressed, and the abovementioned model provides incentives for patients to be cost conscious.

1720

I have detailed areas of schedules H and I that raise particular concerns. Schedule F also contains many problems not possible to detail here. The time allowed to amend this bill is far too short for a bill whose breadth is so immense. More time is required for meaningful evaluation and amendment. The sections pertaining to health care should be pulled out and dealt with individually. Physicians would welcome open discussion.

In any event, there should be a sunset clause inserted that would come into effect within two years. This would at least allow a re-evaluation of whether the goal of providing all Ontarians with cost-effective, comprehensive health care is being met.

I thank you for your time and attention. I anticipate your questions.

Mr Clement: Thank you for a very worthwhile presentation. I think I can speak for all of us on the government side that you've added into your presentation some constructive suggestions, and we can certainly undertake to look at those with an open mind.

I wanted to probe just a bit on some of the items you have discussed. It will come as no surprise to other committee members that I wish to discuss disclosure and confidentiality. There is some misunderstanding, which I suppose is partially the government's inability to get its message out, but also there's some myth-making going on about what is actually in the provisions.

For instance, with respect to inspectors, as I think you would know, under the old act, inspectors had the right to enter a doctor's place of work and have access to material. No one could obstruct the inspector from doing his or her responsibilities. I acknowledge, and you make reference to, the fact that the inspector, under the new legislation, is given the power to remove documents for the sole purpose of photocopying those documents and then returning them, not without notice. Do you see that as unduly broad even in that circumstance, sir?

Dr Leger: There are two issues. The first issue is the criteria by which the inspectors enter the practice. In this situation, there are what will be perceived to be arbitrary, unilateral, broad-based criteria, with no criteria stipulated in the legislation, for these people to come into practices. They can do so under any pretext and remove any patient information.

The second issue is that when they copy it, that information is now gone from the physician's office. The real difficulty I have, that I think everyone has, is that

this information can be published by the minister for whatever purpose the minister deems appropriate. That is provided for within the legislation.

Mr Clement: I gather what you would like to see—I'm fishing for amendments, I guess. The purpose of this section, quite frankly, is to root out some fraud and misuse in the system. I'm not saying it's endemic in doctors' lives, but obviously a fraudulent dollar is a misspent dollar when we've got so many crying needs in the health care system. If there is some connection between what the inspector is doing with that purpose, would that satisfy you?

Dr Leger: In my section where I dealt with potential solutions, I recommended that the criteria whereby services are deemed to be inappropriate, unnecessary or otherwise fraudulent, by your terminology, should be established by objective criteria. That is fundamental to the process.

Mr Clement: I think the college is working on that as we speak.

Let me just talk about underservicing. We just returned from northeast and northwestern Ontario where that was obviously a very cogent issue among your colleagues and the community as well. I understand your concerns about the powers to deal with that.

Previous governments—Liberal and NDP governments before us and PC ones in the distant past—have tried to deal with underservicing for perhaps two decades. The chart that was part of your presentation shows that even prior to the 1995 election, we've had a bit of a problem here which good-faith discussions between NDP and Liberal governments and the OMA have failed to solve. Am I wrong in wanting, on behalf of our communities in Ontario and on behalf of Peterborough, to try to solve this a bit more forcefully, shall we say? Is that an invalid consideration?

Dr Leger: You prefaced your remarks by referring to previous discussions and contractual arrangements. I really don't have the space to address those and I would refer those back to people who are more knowledgeable than myself. What I do know is that at this time there is a proposal before the government from the OMA, in conjunction with PAIRO, to address the underserved area issue in a cost-neutral fashion.

Mrs McLeod: I regret having to begin again by dealing with the issue of access to information. Unfortunately, Mr Clement keeps trying to make his personal opinions the view of the government, and make the legislation what he would like it to be. I thought the government's message was delivered by the Minister of Health, who has said quite clearly and quite publicly that there will be amendments to the access to information because the privacy commissioner has said that this is a grave violation of individual privacy.

In addition to the changes in terms of being able to take patients' records out of doctors' offices, copy them, disclose them, and to the fact that there is no penalty of any kind to the Minister of Health, the general manager of OHIP or any staff member or any other individual for inappropriate use of that material, there is also the very straightforward fact, Mr Clement, that one of the differences here is that up until now the only people who had

access to a physician's records in the office were inspectors who were working under the Medical Review Committee of the College of Physicians and Surgeons, and that is a huge and significant change.

Dr Leger: Thank you for clarifying that.

Mrs McLeod: We have to do it quite regularly, which is why I felt the need to do it again. We thought this was one area where we'd made some gains, and he keeps setting us back.

You've presented very thoroughly a complex piece of legislation, including the dangers of many parts of this legislation coming between a patient and a physician. We're hearing in other communities that there are already concerns leading to physicians second-guessing their decisions about testing and so on. I won't take you into that area, in the interests of time.

I do want to talk a little about the underserved area issue, because I've been coming into Peterborough long enough to know how long Peterborough has struggled to get recognition as an underserved area. I would suggest to Mr Clement that there are some models that help in underserved areas, and all Peterborough has been asking for for years is an agreement from the Ministry of Health that it can use the incentive programs under the underserved area program. I know the Peterborough frustration.

We were in Sudbury the other day. They've had trouble getting recognition as underserved in some areas. The Ministry of Health statistics included three physicians who were dead and one retired physician who gave flu shots to his neighbours as full-time practising physicians.

This act is incredible in what it does to allow the ministry to determine what physicians will be eligible to practise, to set quotas for every community, and if there are more people than will fill a quota—should we be so lucky—the ministry will be able to set the regulations as to who gets chosen to come to a community.

But you've raised the issue of this bill getting in the way of even being able to recruit. The minister's answer to the problem of recruitment of physicians in northern Ontario and in rural Ontario has been to say, "Let's put in place billing numbers"—a coercive method—"but we won't use it unless we have to." Across northern Ontario we heard: "It won't work. Coercion will drive people out, and that, combined with the other measures in Bill 26, will make the problem more difficult." Is that your concern as well?

Dr Leger: You've covered a lot of ground.

Mrs McLeod: I did.

Dr Leger: According to our calculations, the way the ministry derived the figures for our area, we assume we have some dead practising physicians here as well—none of them in this room.

Mrs McLeod: If they were, they'd count for two on the ministry list.

Dr Leger: I agree essentially with what you're saying, that this idea of trying to coerce physicians into a model of management is not going to work. We've been working very hard for the last five, six years to provide services. For instance, in Peterborough we're working with half the number of hospital beds that we did seven

years ago. We've been working under very adverse circumstances and trying to do the best we can.

Trying to coerce people who are doing the maximum effort they can do is only going to have a rebound effect. There has been a progressive exodus of physicians out of this province. A statistic I heard recently was that 50% of the graduating class of the U of T family practice program went to the States. Now, not only are we paying this education cost, we're losing all our human resources.

1730

Mr Marchese: Dr Leger, thank you for your presentation. I have three or four quick questions, if the answers are equally short. One of the stated objectives of the government in presenting Bill 26 is that it would help to deal with our deficit problems. Is there anything dealing with doctors in general here that helps the government to deal with the deficit?

Dr Leger: I can see no way in which this legislation is going to achieve a goal of cost saving. In fact, I would perceive that there would be cost increments required for the bureaucratic administration of this legislation.

Mr Marchese: The other stated objective is that they're trying to deliver a better health care system in order to be able to take care of our population. Much of what you've said is very critical. Is there anything that you have read in relation to the medical profession that helps to deliver a better medical model or better health care system for our population?

Dr Leger: Yes. I did make reference to the primary care models that are available. The college of family practice is a model, for instance, which would in its implication make both service providers—physicians—and patients liable and responsible for costs incurred. So there are primary care models that are available now that would actually help with cost control and cost reduction.

Mr Marchese: But in terms of what they have presented to us here in this bill, is there anything there that you think is good for a good health care system in Ontario, to make it better? Be kind now.

Dr Leger: There is an intent behind the legislation. If one had a magnanimous autocrat, one could perceive that this legislation could be beneficial. But in the practical realities of administration of such a complex document, no. I can't find, for instance, areas where I would perceive there would be cost saving. You're asking me questions that are—I'm a family physician, practising full-time in this area.

Mr Marchese: The questions are related to your field. Is there anything in this bill, of which part you've read—you may not have read the whole thing.

Dr Leger: I read it.

Mr Marchese: Is there anything in this you like?

Dr Leger: One third of it I did not understand fully because of the complexity of the documentation requiring full and complete knowledge of many other pieces of legislation. The parts relating to health care were difficult. I don't have the expertise, but I was concerned about sections relating to the environmental concerns with mining and I had some concerns with the way in which the Corporations Act was being changed, but I did not fully understand the impact.

Mr Marchese: If there is one third that you didn't understand as a medical doctor, can you imagine what the

rest of the population would think about this document? It would be complicated, wouldn't you say?

Dr Leger: Yes, I can.

The Chair: Thank you, doctor. We appreciate your presentation and your interest in the process.

ONTARIO SOCIETY
OF OBSTETRICIANS AND GYNAECOLOGISTS
ONTARIO MEDICAL ASSOCIATION,
SECTION OF OBSTETRICS AND GYNAECOLOGY

The Chair: Our next presenters are from the Ontario Society of Obstetricians and Gynaecologists. Welcome, gentlemen, and introduce yourselves.

Dr Richard Johnston: Thank you very much for the opportunity to present this afternoon. On my right is Dr Marshall Redhill, secretary-treasurer of our section of Obstetrics and Gynaecology of the Ontario Medical Association. On my left is Dr Robert Kinch, former professor at McGill and Western Ontario, an executive vice-president of the Canadian Society of Obstetrics and Gynaecology. Dr Kinch won't be speaking this afternoon.

I will open and Dr Redhill will follow. As mentioned, I am chairman of our section of 600 obstetricians and gynaecologists in the province. The obstetrical and gynaecological care in this province has historically been of the very highest calibre. Comparing any number of statistics regarding outcome, both in obstetrics and gynaecology, it is clear that patients in Ontario have received the very best in care.

More recently, within the past 10 years, with further and more drastic government intervention, careers in obstetrics and gynaecology and the practice itself seem to be under major stress. We are very concerned that not only areas of northern Ontario, but areas of central and southern Ontario may well become underserved in obstetrics and gynaecology in the very near future. Bill 26 may make the latter possibility a reality in 1996.

It has become in the past few years more and more difficult, with rising litigation and malpractice premiums, to encourage young people to enter the area of obstetrics. This obviously impacts on manpower and the ability to provide first-class obstetrical service not only in large urban centres but in smaller central regional and northern regional areas. The very difficult physical and mental challenges of obstetrics occurring 24 hours a day, seven days a week, have diminished the interest of many competent young medical graduates who have now sought careers in other areas and other locales, read "south."

Bill 26 will eliminate the membership subsidy for malpractice, which was introduced by the Liberal provincial government in 1987 in lieu of a fee increase. If this current legislation passes, obstetricians will be paying \$2,000 per month for 1996, and there's every reason to think that in 1997 and thereafter, these fees will continue to increase. With the base fee per delivery of \$245 and the average obstetrician in Ontario delivering only approximately 160 babies per year, it is very clear that for obvious economic and business reasons, many obstetricians will simply no longer be in the obstetrical business. Currently, one would have to deliver 90 babies, approximately, simply to pay our malpractice fee.

There are currently 600 ob-gyns in this province, with only 500 actually doing full- or part-time obstetrics. Of the 500, only 400 carry a balanced obstetrics and gynaecology practice. Of the 400, a small per cent in university centres practise full-time obstetrics.

There are approximately 140,000 babies born each year in this province, and approximately 20% to 40% of these patients are considered at high risk, requiring specialists' care. Other patients simply choose to be delivered and cared for by specialists where available, while others will seek out family doctors or midwives.

Whether or not patients are delivered by family doctors, midwives or obstetricians, patients have very high expectations of their obstetrical provider. The cornerstone in the obstetrical team is in fact the obstetrician. We recognize the very important role that other physicians, anaesthetists, paediatricians, obstetrical nurses, geneticists and midwives play during the course of a pregnancy, but obviously the pivotal, or buck-stops-here, individual can ultimately be the obstetrician. Clearly, our malpractice membership fees and premiums substantiate this as we are paying a fee shared by no other medical group in this province.

At an emergency meeting of our section just this past Sunday, January 7, a question was asked with regard to continuation of obstetrical practice if no changes were made with regard to Bill 26 and our malpractice situation. It appeared that approximately one third of the physicians present were very seriously considering alternative practice patterns. It is ironic that never before have the obstetricians in this province been so galvanized and unified in their response to legislation and what appears to many physicians and patients to be the equivalent of the War Measures Act for health care.

The overwhelming powers entrusted to government in this legislation is beyond the scope of our presentation, and our focus today is simply in regard to our concern that there is a very real threat to the continuation of high-quality obstetrical care for patients in this province.

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We do not understand the virtually unlimited powers enshrined in this document to the Minister of Health. We do not recognize that there is a major crisis in health care warranting such intervention and legislation. Pregnant patients, their complications and newborns are not a doctor-driven situation. We are tired of hearing from various sources about the latter aspects of health care economics.

Everyone in this room and every physician and health care worker in this province recognizes and encourages the need for many changes in health care. No current medical formula, including Bill 26, is perfect.

We agree that there are changes needed within the OMA's structuring and fee schedule, as well as the approach and incentive for rural remote areas of this province, including the provision of obstetrical services in these very places.

In a number of areas of this province obstetricians carry a very high obstetrical load, and any concept of capping these individuals will have dire repercussions for patients in those areas.

Women's health care deserves a better deal from this government.

Furthermore, the current message in the past 10 years, but precipitated more so by way of Bill 26, is a message to medical students and residents: Why would anyone in their right mind consider a career in obstetrics in Ontario?

The maintenance and continuation of high-quality obstetrical care is only possible by the infusion of talented, bright young people, and we are very concerned that obstetrics as a choice will not be on the short list of any young graduate. If it is on their short list, it may be south of the border where many vacancies still exist throughout virtually every state.

Canadian obstetricians are recognized in the United States as a high-quality, guaranteed product. Our undergraduate and postgraduate training is of the highest order. Many Canadian obstetricians occupy university appointments and chair several of the major departments at university centres in the States.

While the emigration for Canadian doctors is listed and reported as only about 2% a year, a disproportion of this emigration is in fact obstetricians. The province cannot afford to lose these highly trained, well-qualified young Canadians.

Our membership and constituents have spoken to us very clearly. Regardless of our leadership, they are very angered and will be making decisions independently as to their continuing decision and choices regarding obstetrical care.

That's the end of my brief. Dr Redhill has a few comments as well. Then the three of us will be prepared to answer questions.

Dr Marshall Redhill: Mr Chairman, ladies and gentlemen of the committee, I thank you for the opportunity of addressing you today. On behalf of the section of obstetrics and gynaecology, I'd like to communicate with you the potential crisis that could arise in the delivery of obstetrical care in the province of Ontario if this government's current agenda, particularly in regard to withdrawal of assistance to the province's obstetricians with their malpractice dues, is implemented.

I want to assure you that the obstetricians of the province are committed to provide excellence in obstetrical care to the women and newborns of Ontario. On the other hand, we are very seriously worried about the safe delivery of newborns in the province if it becomes practically impossible to maintain a high level of specialist service to continue that service in many areas because of the economic impact of the withdrawal of the assistance with the Canadian Medical Protective Association coverage.

The membership of our section is concerned that your government may not have been properly informed of the net effect of this decision and the way in which that decision may, and indeed we believe will of necessity, impair the quality of care to the women and children we serve.

There are, as my colleague's just told you, approximately 500 practising obstetricians in the province who are involved in the delivery of approximately 125,000 babies annually. Now, Dick probably has more updated statistics and says 140,000. As you may also be aware,

due to the Ontario coroners' recommendations, every provincial hospital is currently advised, for public safety reasons, to have an obstetrician on call, even if a family doctor and/or midwife is available to do uncomplicated deliveries, on the staff of that hospital if obstetrics is practised in that hospital.

Needless to say, obstetricians must have malpractice insurance to have hospital privileges to perform obstetrics, even if they are only to be on call for complicated deliveries. Quite frankly, net compensation to an obstetrician for an ordinary labour and delivery, which would average somewhere between six and 10 hours of labour—but there are outside those parameters many women who'd go shorter or longer—if this decision is implemented, will be—are you ready?—\$34.90. Please do not think that I'm either exaggerating or overreacting. This is a fact which on its face should indicate to you that many obstetricians simply will not and cannot continue in obstetrics. The average obstetrical caseload for specialists in this province is about 160 deliveries per year. A little later in this presentation, I'll explain to you in detail how I arrived at this figure.

The section of obstetrics and gynaecology is turning to you in good faith and with a genuine concern for the people of the province of Ontario who have elected this Conservative government into power. We want very much to continue to give women and newborns of this province the excellent and superior care that they not only are accustomed to but, we believe, are entitled to expect from us. We need your help in achieving this. We know that you do not think that obstetricians are creating work for themselves by overutilizing the health care system and we are reasonably confident that within the current government there is a will to maintain the excellence in health care to which Ontario is accustomed.

The CMPA rebate was brought into effect in 1987. It was in lieu of a fee increase in the schedule of benefits for physicians after several years of very minuscule, if any, increase in fees for remuneration of doctors. The "reserve" fund, which has attracted a great deal of attention from the ministry and the press, is the result of good actuarial practice on the part of the Canadian Medical Protective Association. It is in reserve for the entire national picture of Canada rather than just the province of Ontario; it's national. In comparison with the massive unfunded liability of the Workers' Compensation Board and problems with the Canada pension plan, the lawyers' compensation fund and failing insurance companies, the CMPA's reserve fund should be applauded rather than criticized. The increase in premiums over the past several years is due to an increase in court awards, 50% of which is returned to the public coffers via OHIP for subrogated interest.

I'd like now to make you aware of some facts, and I apologize for not having enough copies of this made.

Fact: Obviously, obstetricians do not overutilize the health care system. The birth rate is not driven by obstetricians. Otherwise, we'd all be hauled before the College of Physicians and Surgeons of Ontario. Besides which, we're all too damn tired.

Fact: There are 500 practising obstetrical specialists in the province and, as I said before, 125,000 babies are

delivered annually in Ontario, either directly or indirectly by obstetricians.

Fact: Due to coroners' recommendations for patient safety, every Ontario hospital that has an obstetrical unit must have an obstetrician on call even if a family doctor or a midwife is also on staff.

Fact: Hospital bylaws and standards of practice require that obstetricians handle high-risk pregnancies.

Fact: In 1986, 10 years ago, malpractice insurance for obstetricians and gynaecologists was \$4,900, of which \$1,400 was ascribed for the obstetrical delivery portion of the practice. Today, that fee is now \$24,036, of which \$12,924 is assigned to the obstetrical portion for deliveries. This represents an increased burden of \$11,524 over the base year of 1986 and is the financial burden that we will have to carry if this portion of the bill is passed. This represents \$72 per obstetrical delivery that I do, based on an average caseload of 160 deliveries per annum.

Fact: In 1996, malpractice insurance for family physicians is \$4,332 and for midwives, \$4,500.

Fact: In 1986, 10 years ago, obstetricians in Ontario were paid \$210.30 by OHIP for an ordinary, uncomplicated labour and delivery. Time, on average, as I alluded to before, is between six and 10 hours.

Fact: In 1996, obstetricians are paid \$34.40 more, for \$244.70 for the same uncomplicated delivery.

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Fact: From this \$244.70 payment to the obstetrician the following are our costs of performing that delivery: 10% clawback for overutilization of the system, which will now in the new legislation be called "contribution"; \$72 CMPA insurance, as I've indicated previously; a 10% contemplated decrease in the threshold that we are allowed to bill; 40% office overhead, and 53% income tax.

Fact: The net compensation after all of these deductions for a delivery, representing somewhere between six and 10 hours of labour, both on behalf of the patient and on behalf of the doctor labouring, is \$34.90 with an average of less than \$6 per hour net take-home pay.

Fact: If all prenatal visits, post-partum care in the hospital and postnatal checkup at six weeks in the doctor's office are factored in for a straightforward, uncomplicated pregnancy labour and delivery, the gross pay is approximately, for the entire nine months, or nine yards, \$570, and this works out to a net return, after all those abovenoted deductions, \$110.

Fact: Without the government's assistance with malpractice fees, the compensation to obstetricians to supervise childbirth will make it economically impractical for some obstetricians to continue to practise obstetrics.

Fact: New midwives entering the profession are paid \$55,000 per annum, with government increasing \$2,000 per annum for each year of seniority or grandfathering—that somehow sticks in my throat; it should be grandmothering—to a maximum of \$77,000.

Fact: Two midwives are required to attend together 80 deliveries per annum.

Fact: The gross compensation for a midwife to do a straightforward, uncomplicated patient's prenatal care, labour, delivery, post-partum care and newborn care

therefore varies between \$1,375 for the lowest-paid midwife to \$1,925 for the most senior midwife.

Fact: The government pays for the midwives their drug, dental and extended health care, and also makes a contribution to their retirement savings plan. Their malpractice insurance of \$4,500 per annum is also paid by the government. Their office expenses are completely paid for, as well as their mileage and cellular phones.

Fact: The only expenses which a midwife is faced with paying are her college and midwife association fees. In addition, of course, she too has to pay income tax.

Fact: Enrolment in medical schools and postgraduate residency training programs is reduced by government fiat. More graduates are writing their American board exams at the same time as they write their Canadian fellowship exams preparatory to job hunting in the United States. And as my colleague has indicated, Canadian graduates in the specialties are very attractive in the States.

Fact: This resultant loss of future specialists will threaten research and academic excellence for years and years to come.

As a result of our serious concern about this constellation of facts, the section of obstetrics and gynaecology at the emergency meeting last Sunday passed the following motion which was carried unanimously:

"Whereas the Ontario Medical Association Section of Obstetrics and Gynaecology's mission is to continue to provide excellence in obstetrical care in Ontario, and whereas 500 obstetricians are currently responsible, either directly or indirectly, for the safe delivery of 125,000 babies each year;

"And whereas the government's Bill 26 Savings and Restructuring Act, by its draconian provisions, demonstrates gender insensitivity to the women and newborns of this province,"

The section voted "to inform an alert government to the fact that in the absence of a responsible amendment to the act directly impacting obstetrical service and delivery, a serious crisis in obstetrical care will be created within the year as a result of the forced retirement of significant numbers of specialists from the profession who will be unable to reasonably pay their CMPA obstetric malpractice fees on the basis of the current fee schedule."

In addition, because we cannot be held responsible for utilization levels in obstetrics, a further motion was unanimously carried, and this motion read: "The threshold for obstetrical codes be eliminated."

Interruption.

Dr Redhill: If that's my wife, I'm busy.

Mrs Ecker: It's one of your patients.

Dr Johnston: Somebody's fully dilated, Marshall.

Dr Redhill: Somebody's obviously fully delighted.

All of which is respectfully submitted. Thank you so much for your time and I'd be pleased to answer any of your questions, as would my colleagues.

Mrs McLeod: That was such a compelling presentation that you feel as though no more should have to be said and the Minister of Health should simply revisit this issue immediately.

I'm going to stay with it because, first of all, we don't often have obstetricians coming and presenting that case to this committee and, secondly, because I think this is one of the areas in which there is the potential for an immediate crisis even before passage of the bill.

I have, a combined conflict of interest. The first is that I want my daughter's obstetrician to stay in practice long enough to deliver my first grandchild next month, and the other is that I confess to a personal conflict because my husband has been a family practitioner for 30-some years in a northern community doing obstetrics. He thinks he should get to the point where he stops so he can guarantee a full night's sleep, but he loves it. He's delivering the babies of the babies he delivered. He wants to stay doing it, and he will not because he would actually have to pay for the privilege of delivering those babies. That is a terribly sad situation and indeed, combined with the potential withdrawal of services by obstetricians, does constitute a pending crisis.

The Minister of Health has given some indication that he may revisit this issue for family doctors who do obstetrics. You've made it clear he must also deal with it for obstetricians, but I would ask you to comment. If there was a withdrawal, not only by obstetricians but of family doctors in this area who may do obstetrics, what effect would that have on access to obstetrical care?

Dr Redhill: Before I reply, I must tell you there is not going to be a withdrawal of service. This will be a natural effect for obstetricians who are approaching the long-in-the-tooth situation where instead of retiring at 65 or 67 are going to quit at 62 and 63 and say: "To heck with it. I just can't take this any more." This is a natural result of this sort of economic reality. It will not be a withdrawal of services. There will be doctors who will continue to do obstetrics, and I too am now a grandfather of many children whom I delivered originally.

The impact on obstetrics is plain and clear to see. There are going to be less practitioners to deliver more babies. There are not going to be enough midwives to fill the roles. There are not going to be enough women in the province who are going to choose midwives over either family physicians or specialists. It's just not that popular or large a demand. When you increase the volume that tired, old obstetricians have to deliver, you decrease the care and increase the risk. That is not satisfactory.

Mr Marchese: I have a general question. A previous group this morning in Kingston made this comment where they said, "The role of government is to set policy standards and objectives and the role of medical institutions generally is to manage and administer the system." With Bill 26, what it does at least is to confuse those roles where in fact the government is assuming the role of managing the system, and it presents a problem.

In terms of what's contained in here, I suspect some of you have in your mind that the New Democrats would have been capable of doing something like this—

Dr Redhill: How perceptive.

Mr Marchese: —but we didn't do it. I knew I could assume some things and be quite correct.

They say on the other side that: "We got rid of the Advocacy Act because it's too intrusive. We got rid of employment equity because it was too intrusive and

draconian. But we now have a bill that we need. We need this Bill 26," which is very draconian and very intrusive, but they don't think that's a problem. In your view, is this necessary, what they are presenting to us? Does it help to solve the deficit? Does it make our health care system any better?

Dr Redhill: The brief answer generally is no.

Dr Johnston: And we agree.

Dr Redhill: The College of Physicians and Surgeons has the role to supervise and deal with physicians who abuse their role or are fraudulent. Without being pejorative, this bill criminalizes physicians even more so than previous governments have had a tendency to do. My sense of this bill is that this has been drafted by a Conservative, small business government with a left-wing agenda in a right-wing fashion. Did I leave anybody out?
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Mrs Ecker: I'm a bit speechless after that description of what you believe is happening, but I would like to thank you very much for coming here and taking the time from what I know is a very busy schedule to bring forward your concerns and your suggestions. You mentioned the Medical Review Committee under the CPSO in terms of its powers to be able to look at inappropriate or misused billings or whatever in the system.

One of the concerns the college has been telegraphing for several years now is that this system is not working, that it's costing physicians and the college, your fees to the college, an outrageous amount of money for the time—two, three, four and five years—to get through. When they do find someone, they have not been able to get the paybacks from someone who is actually doing something inappropriate.

They've been suggesting very strongly for some time to previous governments that amendments need to be made, that the system needs to be streamlined, improved, enhanced. Would it be more appropriate if the role to continue to look at the inappropriate billing were to be placed with CPSO with an enhanced, streamlined, more effective Medical Review Committee, where there is a committee of public representation and physician representation which will look at the patient files and the information to make that decision whether or not the medical necessity or the billing has been inappropriate?

Dr Redhill: Janet, you've worked with the College of Physicians and Surgeons. You are more familiar with the machinations of the college than perhaps anybody else in this room. It sounds like you're reinventing the wheel; it already exists.

Mrs Ecker: But they're saying it's not working, though. The college is saying the current system does not work. They say it needs to be changed.

Dr Redhill: Why, because they haven't got 25% of doctors in jail? Maybe there aren't 25% of doctors who are crooks.

Mrs Ecker: Well, if there are, we should be doing something about it. I don't think the percentage is that high, quite frankly, sir.

Dr Redhill: This legislation suggests and has sections in it that keep repeating again and again "inappropriate billing" and "fraudulent use" and "misrepresentation."

Nowhere in this bill is the misuse or abuse of the system by the public, and health card fraud, addressed, nowhere.

Mrs Ecker: Mr Wilson has said very much that, one, smart card technology and stuff to go after that is certainly a priority. Secondly, the only way we're going to get after what you as physicians describe as double doctoring—we know, for example, that in one month 7,000 people went to see more than five GPs in one month, which you think is pretty excessive. The only way to get at that is to have information within the system. I certainly support that because that is money that should be there for front-line services that are needed.

The Chair: Doctors, thank you very much for your presentation. We appreciate the time you've taken to be with us tonight.

NORTHUMBERLAND COALITION AGAINST POVERTY

The Chair: Our next presenters are the Northumberland Coalition Against Poverty, represented by Carolyn Blaind, a member, and Pat Gardner, a member. Good evening and welcome to our committee.

Ms Carolyn Blaind: Our presentation starts out by saying, "Good afternoon." I will begin by saying, "Good evening" instead, and thank you for the opportunity to present to the committee. We are here today representing Northumberland Coalition Against Poverty, a coalition of low-income people in Northumberland county.

Our members include people on social assistance, disability pensions, workers' compensation and people working for low wages. Our activities include speaking out to our elected representatives about issues that concern us, as Dr Galt can tell you. Our presentation is intended to address our specific concerns about Bill 26 with regard to the health sections of the bill. Before we address our itemized concerns, we would like to provide you with some summary information on the determinants of health.

For many years, governments, health care providers and consumers have been involved in studies, consultations and research in an attempt to define health and wellbeing, to predict the determinants of health and to assess the impact of poor health on individuals, families, communities and nations. From these initiatives, numerous reports and statistics have shown us that there is a direct correlation between income and good health or bad health.

Healthy people are those who have the necessary resources for health, one of which is adequate income. With an adequate income, people's opportunities to participate and create healthy communities and societies increase. High levels of health are a means to sustaining independence as individuals, communities and nations. There are no wealthy countries in the world without a high level of health.

To achieve and maintain good health and to decrease costs in health care, we need to foster strong supportive families and communities and to provide accessible, affordable and appropriate services for everyone.

For low-income individuals and families and those who must rely on publicly funded services, the capacity to

provide healthy environments for families is being diminished by policies and legislation that have a negative impact.

Ms Pat Gardner: This brings us to this legislation, Bill 26. Under this bill, amendments to the Ontario drug benefit plan permit the introduction of user fees, co-payments and deductibles for seniors, social assistance recipients and persons with disabilities. Many of those who must rely on this plan have already been hit with a 22% decrease in income and cannot afford user fees and deductibles. Once rent and utilities are paid, there is barely enough left to purchase food. The food budget is the only place left to cut spending and will now be further depleted when families are required to pay user fees for medication. This means the difference between providing adequate nutrition or necessary medication. There is no choice here. Proper nutrition, also being a determinant of health, will be sacrificed.

Further, under amendments to the Ontario drug benefit plan, the government will no longer pay the difference between generic and brand-name costs for no-substitution claims. We interpret this to mean that if a generic drug is not available or suitable, the individual must pay the difference. Because prices will now be set by the manufacturer and Ontario becomes the only province that does not regulate drug prices, we are concerned that costs to those individuals who can least afford it will increase.

We are aware that we face increased costs to the Ontario drug benefit plan, but not because of overuse of the plan, rather because of overprescribing and federal legislation, Bill C-91, that extended patent protection that delays the introduction of generic drugs that are less expensive.

We feel strongly that low-income people should not be made to bear the burden of such irresponsible legislation at the hands of government. With regard to Bill 26, the Common Sense Revolution clearly stated, and I quote, "Under this plan, there will be no new user fees." This promise has clearly been broken to fulfil an election promise of a 30% tax cut that will have no positive outcome for the poor, seniors or persons with disabilities. We urge the government to amend the legislation so that no new user fees for health care will be implemented.

Finally, we are deeply concerned that this bill will permit astronomical powers to the Minister of Health to define what is a medically necessary service, to permit hospitals to charge user fees and to dictate to doctors where, when and how they can practice medicine. For partners to work well together, we need to know our limitations. In areas where there is no expertise, we must rely on those with the scope of knowledge to provide us with the best information on how to do the best job. The government should stay out of the operating room of health.

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We wish at this time to voice our concerns about the fact that Bill 26 gives the Ministry of Health unlimited access to the private medical records of the citizens of Ontario. We are concerned that the information in our private records could be used as a basis for discrimination once the minister is given the power to define what a medically necessary service is. We are also disturbed that

there is absolutely no guarantee that our confidential medical files will not end up in the wrong hands.

Finally, we would like to inform the committee that low-income people are fed up with being labelled the deficit-causing problem of this province. A reduction in the deficit cannot and should not even be attempted on the backs of the poor, seniors and persons with disabilities. Bill 26 attempts this. We optimistically believe, now the members are familiar with the negative impact this will have on all sectors of society, that should Bill 26 go to a free vote in the Legislature, it will not pass.

We thank you for listening to our presentation and will be happy to respond to questions.

Mr Marchese: Thank you for the presentation. One of the things you mentioned that I agree with you on is with respect to the user fee in the Ontario drug benefit plan and how that will affect seniors and low-income people in general. We tend to forget—perhaps not; I'm sure you would have included it if we were speaking generally: The tools this government is giving municipalities will mean municipalities will impose user fees as well on a wide range of things we may not yet know, but if you can think of it, they'll probably introduce it. So municipalities are likely to introduce fees; hospitals and doctors; independent health facilities; the drug plan. My feeling is that when you add it all up, and I'm not sure they've added it all up, the low-income people and seniors will be hurt very seriously. Is that your view?

Ms Gardner: Definitely. As a matter of fact, one of our concerns is that a lot of the user fees that will be imposed by municipalities will be fees for things that are necessities, where we won't have a choice, where we'll have to use these services, such as garbage collection. That's a good example. We might be forced to pay \$1 a week or \$1 a bag for garbage to dispose of our garbage, and that's something we can't do without.

When you add up the fact that 21.6% was taken off the allowance that social assistance recipients receive for their rent, 21.6% was removed from the amount they receive for their other necessities including groceries, and you top that off with the fact that our rents didn't go down by 21.6% so we have to take that out of our food budget, and then add to that the user fees for drugs, which are a necessity, and any municipal user fees that are levied, that creates a lot of problems for people in our situation.

Mr Marchese: One of the concerns we had as opposition members was that this government had not intended to consult the communities in Ontario. They wanted to pass this legislation before December 14. That would not have been a process. It would not have been democratic. It would not have allowed any scrutiny whatsoever with respect to this bill and what we are all now engaged in. The tactics we engaged in allows us the opportunity to get some media attention and force the government, obviously, to do this.

Do you feel, in spite of that, that you've had enough time to review this document? I'm not sure whether you've seen it, read it, parts of it, the whole bill or not. Do you think you've had enough time to be able to review the effects it has on the people you serve on a daily basis?

Ms Gardner: Just speaking for ourselves, we've only been able to have the chance to see a synopsis of the bill. We have not actually been able to see the entire text of the bill, because obviously, as you know, it's quite a few pages of paper and it costs quite a bit of money to get your hands on a copy of it. Obviously, we don't have the kind of funds to be able to get a copy of the bill. I think a bill that size and of that scope requires a lot of scrutiny before you can make a really educated decision on it, but from what we can see in the bill, there are a lot of things in there that will hurt low-income people and seniors and disabled people.

Ms Blaind: We are also of the view, if our understanding is correct, that under this new bill cabinet will be given astronomical powers to pass things without debate or public consultation. We've come up with a little theme around that, that being that if you don't tell the public what you're doing, the public can't tell you what you're doing wrong. We're very much opposed to the whole process of this bill.

Mr Marchese: One doctor, in the previous submission this morning, said that people have to be involved if they are to accept change, or that if we're going to have good change, if people are not involved that change is likely not to be very effective. I agree with your remarks.

You alluded to the income tax cut. You serve people who, generally speaking, are low-income people. We understand that the income tax cut a low-income person will get is very, very little, and these are the people who normally would spend. We estimate that 60% of the income tax cut is likely to go to the top 10 percentile of the population. We think those people who are going to benefit from the income tax cut are the wealthiest citizens of Ontario, who are not likely to spend, who are not likely therefore to kick the economy into shape. We think this will benefit the very wealthy and will hurt as a result of taking money out of other areas to service this income tax cut. Have you done some thinking in this area?

Ms Blaind: Definitely we have. As a matter of fact, one of the first things we discussed at our meetings when we heard there were going to be these 21.6% cuts was the fact that this money that's coming out of people's welfare cheques is coming out of the local economy. Everyone who is on social assistance spends all their money each month; they put it right back into the economy at the grocery store, at clothing stores, just to buy the necessities of life they need every month. This money has now been taken out of the economy, and that effect will be increased when more money is taken out of the economy to pay municipal user fees and drug fees. We have definitely looked into that.

Mrs Johns: I'd like to thank you for your presentation and for your information about the poor you represent in Northumberland.

I'd like to say that I don't believe this government—and you know Dr Galt, so you know well that this government isn't an uncaring, unthinking group—is blaming the poor for the financial situation of this province. The interest the province is paying on the deficit is leading the province to be unable to pay for things we have had in the past. The province must be healthy for individuals to be healthy, for us to maintain

a healthy health care system. We're trying very hard to allocate money to be able to have a healthy health care system, that we may all use it.

I wanted to talk about the drug benefit program and the user fee. What has happened in the past is that other governments have had to take drugs off the formulary or the list that would be covered by the government, to be able to put others on it or to maintain a standard so we could live within the health care budget for drugs. This government is fairly concerned about that and we're looking for ways to control this program so we can put more drugs on it, because new drugs are becoming available all the time that we would like to put on to this formulary. If you don't think a copayment fee is the right way to go, have you got any suggestions about what you think we should do?

Ms Blaind: First of all, overprescribing is a problem, definitely a problem. In terms of some of the things that were delisted by the previous government, having worked with the population who are clients of that program, there were many medications that were not necessary, were contraindicated, medications that were prescribed over the phone before an individual had seen a physician. These are some of the things you want to be looking into. Nobody that I know of in Ontario, with the exception of someone holding a medical licence, prescribes their own medication, so you don't blame the individual for the overprescribing of the drug, you don't blame the individual who's the recipient of that medication because we have exorbitant drug fees from the Ontario drug benefit plan; you look to cause and effect. A copayment is like a tax on people who don't prescribe these medications for themselves, who can't afford them. I think you want to back up a little and look at why it got there.

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Mrs Johns: You say at the bottom of page 3, "Further, under amendments to the Ontario drug benefit plan the government will no longer pay the difference between generic and brand-name costs for no-substitution claims." We heard from a couple of groups that approximately 6% of people can't take a specific drug—it would depend on the drug, obviously. We had a definition from one of the groups in the past week that 6% couldn't take a substitute product. They felt that in terms of the "no substitution," we should make an exception for that 6% and ask everyone else to take the cheapest drug available in the system, if it's generic. Do you agree with that philosophy?

Ms Blaind: I think it's an individual thing. Having worked in the system, I question that 6%; that sounds rather low. In some cases generic drugs use fillers, and if you have an individual plan of treatment for someone using the Ontario drug benefit plan who has a chronic illness or disease, you need to look at that whole plan of treatment and maybe that whole plan of drug therapy. If you look at the generic drug, on its own it might be fine, but if there are other medications where a generic drug is contraindicated, there has to be a substitution for that. Otherwise, you're looking at increased health costs and this individual ends up back in the emergency room because their drugs didn't interact well.

Mrs Johns: Can I just paraphrase, and you can say if this is what you're saying.

Ms Blaind: I'll tell you if that's what I said.

Mrs Johns: I don't want to put words in your mouth. You're saying that if we allow the cheapest product unless there's some problem with the person's health, that would be all right with you; if there truly was some reason a person would react, we should change the "no substitution."

Ms Blaind: If a generic drug is available and it'll do the job, yes. Our members don't have any problem with that. Generics have enabled individuals to access medication that's a whole lot cheaper—and not just on the Ontario drug benefit plan. I'll give you a good example. Tagamet, when it first came out, was a brand-name product, and when the generic drug ranitidine was introduced, there was a difference of \$40 in price per prescription. The problem we have now—again it goes back to cause and effect—is that C-91 interfered, gave patent protection to brand-name companies, so we're not going to have the generic drugs available. That also has to be considered. We can't just give a blanket statement saying, "Anybody in the Ontario drug benefit plan has to have a generic drug." You have to look at the federal legislation.

Mr Miclash: Thank you very much for your presentation. I must say I'm a little blown away by the comments made by Mrs Johns regarding a caring government when we take a look at the care this government has given us in withdrawing \$1.5 billion out of our health care, the caring government that tried to ram this bill through before December 14 with no public input at all, public input for which we had to literally hold the Legislature hostage and which we finally got, which puts us here this evening. We must remember that this is a finance bill, a finance bill to ensure that Mike Harris gets his 30% tax reduction to the rich. That's the way we see it.

I go back to the presenters and ask, do you know of any input into the drafting of Bill 26, or were you involved in any input in the drafting of this piece of legislation?

Ms Gardner: No, we certainly were not. As a matter of fact, another group in our area with which we are acquainted did want to have some input. They were quite willing to have their own input, and were turned down.

Ms Blaind: Do you mean prior to the introduction of the legislation?

Mr Miclash: That's right.

Ms Blaind: There was no consultation that we know of around that, and I fully believe that a lot of the members didn't know what was in this bill either. Send it to a free vote, now that they know.

Mr Miclash: I appreciate that comment. I've asked that question as we've moved around the province and haven't yet found a group or individual who knows of anyone who helped in the drafting of this legislation.

Mrs McLeod: There are a lot of reasons we're glad this did not become law on December 14 or December 23, as the government had wanted. One is that we keep having hints from the government that there may be changes now it's begun to realize the impact of this bill.

For the record, Mr Chair, we've just had some indication of another potential change, that there would be a process for substitution where a particular generic drug is not an appropriate treatment. I hope we are going to see in place at least some process for exception when we finally see amendments.

You've touched on two areas in terms of changes to the drug benefit plan. I want to come back to one you touched very lightly, and that's the deregulation of drug prices. Obviously, there's a concern about copayment for those on the Ontario drug benefit plan, and if we have time I'll ask you to expand on that, but this deregulation issue affects every low-income earner who is not on the plan.

We've become very frustrated over the course of the week, because every presenter has had a different view of what this might do to prices of drugs. One thing that has become clear is that it's most likely to cause higher prices of drugs in smaller communities where there's less competition.

The Minister of Health before Christmas had said the way it might bring down prices is that the big pharmacies, the chain pharmacies, may drop their price, because they do a big volume. The chain pharmacies presented to us this morning and said they were not commenting on deregulation because they had no idea what it would do to prices.

One thing the Minister of Health has said is that there will be differences in prices for drugs from one pharmacy to another and that people should barter to get the best drugs. I'd like you to comment on how feasible you think it is for the people you're working with, to think of a single mom with a sick kid going out and trying to get the best price for the drug for that child.

Ms Gardner: As a single mother myself, I'd have to say that first of all, when you live in a small town you have a very small choice of pharmacies to go to. Second, when you have a drug card, you take it in whenever you have your first prescription that month and put it into that pharmacy, and it's quite a hassle to go to a second pharmacy and get them to call the first pharmacy and verify that you have put your drug card in there. It's a lot of hassle when you're driving a sick child around town, going to this pharmacy and that pharmacy and having to go up to the pharmacist and say: "How much are you charging for this drug? How much would you charge me if I gave you this prescription?" I'm sure it's not fun for the pharmacist either, who is usually busy and has a lot of things to do. He doesn't want to have to go running to the back and check and see how much he's going to charge you for that drug when he's got 15 other prescriptions to fill.

Mrs McLeod: Copayment: Let's look at the effect on particularly a disabled individual and a psychiatrically disabled individual. We've been told that somebody with a psychiatric disability might be on as many as four to five prescriptions, that they are filled in small volumes, for obvious reasons, so they may have to have those prescriptions filled on a weekly basis, so at a minimum, with a copayment of \$2, that individual might be paying \$10 a week or \$40 a month to have those prescriptions filled. Given the people you work with, you have a sense of the

face of poverty in your community. What does \$40 a month mean to a psychiatrically disabled individual on a disability allowance?

Ms Blaind: They're not going to take their medication, because they're going to have to choose whether they eat or whether they take their medication.

The Chair: Thank you, ladies. We appreciate your interest in our process and your presentation.

ONTARIO PUBLIC SERVICE
EMPLOYEES UNION, REGION 3

The Chair: The next presenter is from the Ontario Public Service Employees Union, Region 3. Good evening, and welcome to our committee. Identify yourselves so Hansard has a record of it, please.

Ms Bonnie-Lee Baker: I'm Bonnie-Lee Baker from OPSEU Local 345.

Ms Annemarie Powell: I'm Annemarie Powell, provincial health lab employee. That's OPSEU Local 339.

Mr Thomas Veitch: I'm Thomas Veitch. I'm president of the Peterborough and District Labour Council.

Ms Baker: Our country's health care has always been the envy of other countries. This bill destroys everything Canada stands for: freedom to choose, the choice to make a decision to be someone who can make a difference in your profession. Privacy and confidentiality between a patient and their doctor will be eliminated by this bill. Doctors' hands will be tied as to where they can live, what tests and medications they order, and they will be forced to share with a non-medical, unqualified person in the government patients' records.

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The government can appoint a supervisor who can close a hospital or force them to form a corporation with another hospital without considering the consequences that could happen to patients. Also, more people will become unemployed with the closing of hospitals and other services. User fees will allow only the patients who are financially stable to have the best health care, where the less fortunate will not.

Ontario is very fortunate to have doctors that are caring, well-educated human beings, who will become powerless to treat their patients how, when and where they need to if this bill becomes law. Simply put, this bill is a dictatorship that Canadians have fought long and hard against for years.

The one thing I have not read or heard is how actual patient care will be affected. It is a sorry day when doctors and health care workers have to implore the politicians to allow them to provide the health care they have been trained to do without asking permission of the government and to ask that user fees not be forced upon the patients that are the less fortunate.

Ms Powell: I am here representing the provincial health laboratories of Ontario as well as my union, OPSEU. I'm proud of both those things and I feel this Bill 26 is threatening both those things. I'm a very fortunate person in that I chose a caring profession, and I continue to practise that profession and I want to continue to practise that profession. I'm also a believer in unions because I believe in a decent wage for a decent

day's work and I believe in a decent standard of living for the people of this province and, as a matter of fact, for the people of the world, if it's possible. I'm an idealist, but that's fine. It makes my life good.

The provincial health labs have been around for a lot of years. We've filled different roles, whatever was required of us. At the present time we are mainly fighting infectious disease. We're the front-line workers on that. We're the experts in TB; we're the experts in AIDS; we're the experts in many of the new, emerging viruses; we look after sexually transmitted diseases; parasites; we test well water in our community to make sure that everyone that's on a well is drinking safe water. We go to outbreak situations; we help coordinate; we look after food poisonings.

That's what we're doing these days. We used to do more routine laboratory work: throat swabs, urinalysis, the sort of things that the private health labs have now taken over. But over the years that has been basically taken away from us by the private health labs and we have been left handling the more, as I see it, important things.

You might actually compare us to the Centers for Disease Control in Atlanta for the province of Ontario. We track diseases and we keep them under control, and infectious disease is a fact of life. It still is; it has been in the past; it's going to be in the future. TB is a fact of life in this province. It is not a dead disease; it is a living disease. I know. I worked with it for the last two weeks. I saw some of it. It's still there.

AIDS is an epidemic, and anyone who knows anything about Africa must have seen the reports on whole villages that have their young population totally wiped out by this disease. The grandmothers and the young children are left. Anyone who thinks that can't happen in Canada doesn't understand infectious diseases. They don't respect boundaries, they don't respect political parties and they don't respect income—not entirely anyway.

We at the provincial health labs find this idea of the lean, mean 1990s kind of amusing. We've been lean for a lot more time than the 1990s. Ever since the 1970s, we have been getting leaner and leaner. I hope we haven't been getting meaner and meaner. As a matter of fact, I think the opposite is true. The idea that we have all sorts of extravagance going on is a very, very, very old idea and it simply is not true any more. We are about as lean as we can possibly get and probably even less than we should be.

The private labs make a profit, and they make a profit from the tax dollars of the citizens of Ontario. We do not. We work on a budget, and a budget that's been more and more restricted over the years. Because we've worked under leaner conditions, we have gotten smart and we have gotten efficient. We have gotten good at what we do. What I take from this bill and the rumours I have heard—there's talk about privatizing us, and it just does not seem reasonable. We do a good job and we do it for a lot less money than the private health labs do. We don't take any money out of the taxpayers' pocket. We give you your money's worth.

We spend a lot of time these days watching our own team members, though. My son was a hockey player in

his younger days. He was a goaltender, and I remember one game where one of his own players was scrimmaging for the puck in front of his net, got the puck and then immediately turned around and put it in his own team's net and lost the game. I talked to my son afterwards and I said, "That's really too bad," and he said, "Well, mom, that's one of the things they teach us as a goalie. You have to watch the other team just as much as you have to watch your own."

These days, where I'm working, we seem to be doing an extraordinary amount of watching our own team. It takes an extraordinary amount of energy to deal with all this downsizing. Are we going to lose our jobs? What's going to happen? Are we going to be out in the street? Are we going to be on welfare? We want to do our jobs. We're trained that way. We're all well educated.

I can tell you, when I went into this profession, I did not do it to become rich. I did it because it's the profession that I wanted to do and because I get deep satisfaction from doing it. I did not go into this profession because of the cushy pension at the end of it. That was not my motivation and it isn't my motivation now. Like the lady who was here before, I'm getting a little resentful of that finger being pointed at me. For some reason, by doing my job and doing it better and better and better, I have become the reason for the financial ills of Ontario. It just doesn't make sense to me.

Quite frankly, my household budget is in good form. I have a mortgage. I have a bit of money on my credit cards. After all, it is January. Other than that, my budget's fine. I've done okay. I certainly have to say I resent the fact that as a public servant, I am being told that because my government owes billions of dollars, it's somehow my fault. It isn't. It is not my fault.

I would just like to ask you for your support so I can go on doing my job and go on protecting you people and your children and your grandchildren from possible disaster from infectious disease. I thank you very much for listening to me tonight.

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Mr Veitch: I would like to speak on the impacts of Bill 26 on this community and on this province. Never before has a piece of legislation been proposed by any government that would give them the powers that this bill will. The ramifications will be devastating to this and many other communities. Peterborough has an aging population. Health care is important to them as it is to the rest of this community. This bill gives the Minister of Health the right to close hospitals. This is something we find abhorrent.

The decision as to whether or not our community can support two hospitals must be decided by this community and not some bureaucrat in Toronto. The loss of service would be detrimental to the wellbeing of this community. Both Civic and St Joseph's are already making attempts to develop ways to ensure their continued existence by sharing services and equipment. They have gone as far as to establish areas of operation that prevent duplication of service, thereby making them viable and symbiotic in their relationship. This works for us.

User fees: Seniors and social assistance recipients will have to pay \$100 a year for medically necessary prescrip-

tion drugs plus more than \$8 for each prescription. Think about it. With the changes to social services and the amounts paid to recipients, this is outrageous. As for seniors, they're already living on fixed incomes that are generally below the poverty line. This prompts me to ask, where's the justification for such a move? These people, and the impacts on them, are at the least likely to afford such fees. This is a criminal act on the part of government, as they're effectively causing the people to make a choice: eat, pay the rent or buy the drugs required to make them better.

My own mother, who lives in Toronto, will be forced to pay out \$100 for the high blood pressure medication she requires, an outrage, considering that she lives on less than \$600 a month. She pays her taxes on time and has worked all her life. She too will be forced to make a choice or be subsidized by family members. We love this woman and we'll ensure that she sticks around, but how many others out there don't have anyone?

The province will remove the ceiling on drug prices under Bill 26, making us the only province that does not have a drug ceiling. Who will benefit? The government, the taxpayers? No. Drug companies will be the winners, not us. And this prompts me to ask, why? What possible benefit is there for Ontarians to remove the drug ceiling? Prices will soar, and we will all have to pay. Imagine the revenue that the government will lose when prescription drugs become part of the underground economy.

We've already seen the effects of government trying to privatize lab work and know the cost in comparison is much higher. All this is doing is providing yet another means to privatization. Eventually I see that our hospitals, clinics and labs will all be privatized, opening the door to a two-tier system of health care: those who can pay go to the top of the list, while those who can't wait until the service they require is in the budget.

Confidentiality: We've a real problem with this one. Despite assurances to the contrary, if this part of the bill is passed as written, we will face having our innermost secrets revealed by the government and the Ministry of Health to employers, prospective employers and the community at large. My health is my business, and its treatment is the concern of my doctor. He is a trained professional. We're the only ones that should have access to personal files, and not the ministry.

Hospital fees are to increase under Bill 26 in an attempt to recover lost revenues.

The solution is simple. Take my 30% of the tax cutback, put it back into the social and health services where it belongs. As well, start taxing the corporations in this province at a reasonable rate, not the current 2% to 4% that they pay now. Start with drug companies, Liberty Mutual and other health care insurers.

As to dictating where a doctor can practise, I always thought we lived in a democracy. Yet I hear the government will dictate to doctors where they can practise, or no licence. This must be the new reality of the Harris government: Don't listen, look to business for your support, and ignore the electorate. Obviously, the current government is not looking for another term in office.

So there you have it, the presentation of the Peterborough and District Labour Council. Thank you.

Mr O'Toole: I'd like to thank the members for the presentation. It's important to hear from all the constituent group, and more specifically, I'd like to recognize the impassioned remarks by Annemarie. I appreciate your comments and just draw to your attention that just recently the minister has announced the dialysis unit for Peterborough. You're aware of that. And further, the immunization program, some \$5 million for measles vaccination which is going on now, and also at the same time there's \$5 million in the immunization for hepatitis B.

I recognize what you're saying and I believe also the minister does as well. The question I have for you is not a question of throwing the ball back and forth or that I would disagree with you. I myself have five children and I consider myself to be a compassionate, responsible citizen. I'd sort of put it to you: Do you think that the money is the problem? We're already spending \$17.4 billion in health care overall. Now, do you think really that spending more money is the solution or do you think that real rethinking and real change is part of the solution as well?

Ms Powell: The solution for what?

Mr O'Toole: For the overall management and delivery of health care in this province. The question again, just to be brief: Is spending more money the solution, or is it to re-examine the priorities that we're spending it on? When I think, "Does everyone have to go to Toronto to get things done?" what we're trying to do is redistribute the delivery of health care fairly across the province, and to do that there's some hard restructuring that has to be thought through. Do you think more money is going to solve the problem, or should we restructure?

Ms Powell: I don't know the answer to that.

Mr O'Toole: That's really what this is about. It's my sense that we're attempting to restructure the delivery of health care. The redeployment of doctors in underserved areas has been talked about for 20 years. No one has had the courage to make the tough—unpopular sometimes—decisions, the fee for service—

Ms Powell: Yes, I understand what you're saying and I understand there are tough decisions to be made. I guess I speak from my own point and from my own experience. I am just talking for the provincial health labs and I am saying, in that instance, that it isn't even an economically feasible decision. It isn't an economically feasible decision to privatize us, to start with. We do a good job for less money.

I do not know how to fix this. If I did, I would probably be running for Parliament, but I'm not. I'm sorry, I'm not an economist. That's not what I studied and it's not particularly what I'm interested in.

Mrs Ecker: Come and run.

Mr O'Toole: That's why I ran. I would suggest perhaps that's why I ran, to make fundamental changes, and really that's what we're really trying to do. But there are great powers of strength, be it the doctors, the pharmacists, the anaesthesiologists, all the groups in the hospitals, that have difficulty breaking down the structures and redeveloping a plan that's affordable and effective, with quality health care.

Ms Powell: I understand. I think what perhaps your government doesn't realize is that these changes have

been going on for years. This is not news to us. We have been doing this, and you're right, it takes a lot. There were a lot of little kingdoms out there and we have had to learn how to cooperate. But then that's a change in our society, and it has happened. It has happened in our institution and I'm sure it has happened in other places. This was my point: We have gotten leaner. But we really are at the breaking point. I can identify with the doctor who sat here and said, "I'm tired." I'm tired too, and I'm not 62. I'm 51, and I'm tired.

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Mr Miclash: I must say that I hope the statements from the member opposite in terms of caring will translate in his free vote on this legislation come January 29. It's going to be interesting at that time.

Folks, let me read to you about schedule L, the amendments to the Public Service Pension Act and the Ontario Public Service Employees' Union Pension Act. It reads: "The net effect of Bill 26 is to remove protections for public sector workers which all employees would normally have in relation to their pension plans and give cabinet the power to decide if the pension plan provisions and relevant benefits on windup will take effect. Bill 26 prevents any access to the courts remedy as a result of this legislation. Any employee who made additional payments to the plan since January 1, 1993, because of a plan windup would be entitled to reimbursement for those payments." That's the impact that we feel Bill 26 will have on that plan. Could you maybe comment on what I've just indicated?

Ms Baker: It's supposed to be health care.

Mr Miclash: Yes, but it also deals with the pension act as well, and what I'm looking for is feedback here.

Ms Baker: But today we're supposed to be talking about health care.

Mr Miclash: I thought as members of OPSEU you might want to give me a comment on that.

Ms Baker: No.

Mrs McLeod: In that case, let's return to the issue, appreciating the fact that you are concerned about health care. You've indicated in a general way your concern about the powers that this bill gives to the government and to the Minister of Health, and you're right: Somebody said earlier in the week that this bill gives the Minister of Health the power to practise medicine without a licence. He does that not only through the ability to make decisions to close down hospitals or to appoint somebody else to make the decisions to close down hospitals, but it gives the Minister of Health the ability to make decisions about hospital care without any regard to the legislation or regulations under the Public Hospitals Act, so he is truly acting unilaterally. It also provides absolute protection from liability for any decisions that may be made, funding decisions or decisions about hospital management. These are enormous powers, and I believe your concerns are extremely well founded.

We also have to keep coming back to what my colleague said earlier, as we hear repeated expressions of concern from the government members, that this is a bill about taking \$1.5 billion out of the health care system and having the power to do it fast because the Minister of Finance needs those dollars for his deficit. If those

dollars are not coming out of the health care budget, then the Minister of Finance has not in fact made the cuts that he said he had made.

I agree with your last statement; I think these kinds of cuts are going to push health care past the breaking point. So I share your concerns.

Let me ask you one specific one, and I'm not sure if you would feel comfortable addressing it, but you did mention that in the lab testing area you're working with HIV/AIDS patients in the testing. One of the concerns that's been expressed is that disclosure of information, access to information under this bill, will make individuals with HIV/AIDS very hesitant to come forward for a voluntary testing program in Ontario. Would you want to comment on whether that's a concern for you?

Ms Powell: Again, I'm not sure that I'm qualified to address that. I do know that the sexual health clinics go with anonymity and it does seem to work. This is a very touchy area for a lot of people and it's open to big discussion. I know if I had AIDS I certainly wouldn't want everybody to know it.

Mr Marchese: I want to make some comments and then if there's time for questions I'd like to direct them to some of you. Annemarie, I was very concerned about the comments you've made with respect to the privatization of the labs. I have to tell you I take very little comfort in anything the members opposite are saying with respect to how much they care. This government drools at the thought of privatization. They just can't wait. It's coming. The only way to avoid the privatization of some aspects of health or other aspects of things that we control as a government is through the kind of interventions that people are making in these kinds of consultations we're having at the moment. Without it, you can bet your life that they will privatize whatever is within their control.

We've seen in Mexico that when the government decided to privatize there, we had billionaires become the recipients of the privatization and the rest of the population left entirely poor. It's not entirely new. It happens everywhere. They know it, we know it, but they're still going to do it. Anyway, I didn't want to disappoint you or to make you despondent about this whole thing, but I think people need to be politically sharp because this is the reality as I see it.

Downsizing is going to hurt us, no doubt about it. They say no. They say: "We have a deficit. People gotta go." Where do people go? They go into a very weak economy. Unemployment is now hovering consistently at 9% or 10%, and it's likely to remain that way. So where do these people who work for the government delivering the services go? They go on unemployment at reduced levels that the Liberal government is engaged in, and then on welfare at the reduced levels that this government is engaged in. That's what you have. It means you don't contribute through the income tax system to the government. You're not paying anything. You're just receiving from the government, impoverishing it and impoverishing us all. That's what's happening. Can we convince them? I'm not sure. The only way we can do this is if the public, of course, remains vigilant and decides that

they're going to fight back as they see the introduction of bills of this nature.

The question I had concerns public and civic participation, because I believe that if there's going to be any change in any field, you need the participation—in this particular example, of health care providers and health care users. Were any of you ever consulted? Had you heard about this government doing this in the short period of time that they were in government? Had you heard that something was coming up, and did you think somehow you might be consulted? Did you know? How did you know? All these questions are things that are important to us because I think we're shutting the doors on public participation. I'm interested in knowing how you got involved in coming here to address issues contained in this bill.

Ms Powell: As far as I know, there was no consultation. I got involved through my union. They keep track and they are concerned.

Mr Marchese: Do you believe we need more time to be able to properly assess a document that one doctor said, having read it, he can't understand a third of?

Ms Powell: Yes, I do. Yes.

The Chair: Thank you, Mr Marchese.

Ms Powell: I beg your pardon?

The Chair: I was saying thank you to Mr Marchese.

Mr Marchese: He just shut me off.

The Chair: We appreciate your interest in our process in coming here tonight to present to us. Thank you.

CANADIAN UNION OF PUBLIC EMPLOYEES DURHAM, NORTHUMBERLAND KAWARTHA AND HALIBURTON REGIONS

The Chair: Our next presenters are the Canadian Union of Public Employees, the Durham, Northumberland and Kawartha regions. I believe appearing on their behalf are Gwen Hewitt, Marie Boyd, Casey Thomson, Bill Nichol, Jim Woodward and Randolph Millage. Good evening and welcome to our committee.

Mrs Gwen Hewitt: Good evening, Mr Chair and members of the committee. My name is Gwen Hewitt. I am an employee at the Minden Hospital, which is in the Victoria-Haliburton riding. To my immediate right is Casey Thomson, an employee at the Oshawa General Hospital; to my far right is Bill Nichol, CUPE national staff representative from the Oshawa office; to my immediate left is Marie Boyd, an employee at the Fairhaven home for the aged in Peterborough; and to my far left we have Jim Woodward, legislative liaison, CUPE.

I'd like to draw your attention to the "List of Appearance." There is an inaccuracy on the inside page, listed Local 2225.6 and 2225.12. The employees are representative of Marnwood Lifecare Centre, if you would please make that change.

This evening we will be presenting chapter 1 and chapter 2 of our brief. Appendices A and B reflect the resource materials that we have used.

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On behalf of the 90 bargaining units and the 9,000 members represented by the Canadian Union of Public Employees, many of whom are present with us this

evening—these people live and work in the Durham, Northumberland, Kawartha and Haliburton area—we wish to thank the committee on general government for allowing us to make this submission. At the same time, we recognize that hundreds of citizens' groups in Ontario have been denied the opportunity to consider the Savings and Restructuring Act. This is because of the government's great haste to do quickly the enormous task that needs to be done wisely and with respect to the due process that underpins true democracy.

I live in the village of Minden. My husband owns a small business. We have two children, one of whom requires frequent medical care, and I have been a health care worker for all of my adult life. Casey Thomson lies in Lindsay and works in Oshawa. Marie Boyd lives in Peterborough and works at the Fairhaven Home for the Aged. Together, we have almost 50 years of experience in the health care field. We are involved in community activities ranging from sporting activities to fund-raising activities.

We work in three different provincial ridings. In the last election we voted for the candidate we believed would best serve our communities. Each of our chosen candidates had experience in municipal government and advocated excellence in public health care, education and social service. Ironically, each of our chosen candidates represented a different party.

Our experiences are pretty much representative of the CUPE members who live in small towns and rural communities. We are ordinary people who share in every aspect of community life. We work hard for modest income. Our average annual wage is just slightly under \$30,000, and many of us work for a great deal less. In fact, nearly 40% of our health care workers are part-time employees. We live, work and spend in our communities. We don't send our money to fancy head offices on Bay Street whose governing boards are filled with ex-politicians or to tax shelters in foreign countries. We go to our local merchants to purchase the necessities of life, and some weeks we don't have enough to go around.

So today's submission is not about the ideology of a particular political party. We understand that true democracy doesn't guarantee that every viewpoint will prevail every day, but only that every citizen be entitled to participate in the process and be given a fair hearing in good faith.

The process of hurrying passage of the Savings and Restructuring Act is anti-democratic because it denies the basic right of citizen participation. It seeks to enact some of the most radical changes to our governance without being the least bit concerned that ordinary citizens are accurately informed, consulted, given the opportunity to voice an opinion and afforded the respect of a fair hearing. That issue alone unites the members of CUPE, regardless which political party they support, and brings together workers, small business people and others dedicated to promoting the wellbeing of their communities.

Moreover, the Savings and Restructuring Act goes far beyond the traditional ideology of the Conservative Party. It lacks responsibility and accountability. It seeks to destabilize communities, drive wedges between various

social groups, tear apart our network of social services and victimize workers. If this is a new ideology, then we submit it is one that even traditional Tories will emphatically reject. It will be the first explosion in a chain reaction that will lead the provincial Conservatives to the same destruction that Brian Mulroney bestowed upon their federal counterparts. Only a few short years ago, Prime Minister Mulroney exulted at having a huge parliamentary majority. We all know what happened to the federal Tories when the electoral body spoke.

So it is that we recognize the government has gained a majority of seats in the Ontario Legislature and a mandate to reduce the provincial deficit. We acknowledge that actions may be taken which are contrary to our desires as public employees, rural residents and ordinary citizens. But we will not be forced into servitude without subsistence and will vehemently resist all attempts to undermine the basic democratic orientation of our communities.

We ask that the committee on general government insist that more time be taken to consult with all stakeholders on the ramifications of the Savings and Restructuring Act. We agree with the proposal of the Windsor and District Chamber of Commerce and the Windsor and District Labour Council that at least six months' time be allowed to give Bill 26 the second sober thought it deserves. We need to ensure positive outcomes for Ontario's precious communities. We agree with the expressed opinions of the majority of the academic, religious, socially committed and labour communities, as well as the commentators of all political stripes, that Bill 26 needs to be broken down into rational segments which are comprehensible to the cabinet ministers, elected representatives and affected population. We ask that you protect the collective interest of communities in Ontario.

Marie will continue the presentation.

Ms Marie Boyd: The Savings and Restructuring Act appears to be an unprecedented grab for power by ministers of the provincial government, yet even they profess not to understand its real scope and effect. Clearly, the act amends at least 47 statutory regimes and potentially affects a great many regulatory authorities. It is a massive document which defies comprehension, even by its authors, who are exceedingly reluctant to come forward and explain exactly what it means to elected officials at various levels of government and the Ontario people in general.

With the help of our legal counsel, Sack Goldblatt and Mitchell, we have developed the following understanding of Bill 26.

On November 29, 1995, the government introduced at first reading the Savings and Restructuring Act. This unprecedented and sweeping omnibus legislation contains 17 schedules which enact or amend over 40 separate pieces of legislation. If passed, this bill would vest in cabinet and ministers of the crown the unconstrained power to make decisions affecting the delivery of public services, together with the operation of public institutions. In many cases, these decisions could be made by regulation, ministerial direction or administrative order, without parliamentary debate or meaningful opportunity for public scrutiny and without community, local or stakeholder input.

This bill would also grant cabinet and appointed officials the authority to make decisions affecting important individual and group interests and societal values in many areas, including denial of public benefits, removal of access to public facilities and resources, loss of the right to earn a livelihood, interference with vested rights and disclosure of confidential information, without traditional procedural safeguards, in many cases without a hearing or any right of appeal to the courts. These powers are granted in the broadest of terms, without the statutory limitations or conditions traditionally provided in order to ensure political accountability and effective recourse to the courts.

The bill also contains provisions authorizing cabinet or ministers to extinguish contractual rights and obligations contained in existing binding agreements and to prevent enforcements in the courts. These provisions specifically apply to agreements between the government and the Ontario Medical Association and the Ontario Public Service Employees Union. The bill would also extinguish the statutory bargaining rights of the Ontario Pharmacists' Association and seriously undermines Ontario's long history of relatively harmonious relations.

The bill would empower cabinet or ministers to make regulations or to issue directions overriding the provisions of any contractual agreements and even overriding or providing exemptions from the provisions of other legislation. The bill also purports to reverse and render of no effect certain decisions already made by courts or tribunals under existing legislation and agreements and to insulate the government against liability arising from future court or tribunal decisions. These measures constitute a serious attack on our judicial or quasi-judicial bodies which endeavour to provide fair hearings and objective dispute resolution.

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In all of these respects, the bill goes far beyond merely enacting the provisions of the Treasurer's economic statement of November 29, 1995. It fundamentally alters democratic processes to autocratic ones. It diminishes the authority of arbitrators and others dedicated to dispute resolution and immunizes ministers from liability for their actions.

The complex provisions of Bill 26, running over 200 pages, affect many areas of public life, including:

Providing unilateral powers to the Minister of Health and cabinet to fundamentally restructure the operation of public and private hospitals and independent health facilities, while at the same time eliminating procedural or substantive protections against adverse ministerial or hospital decisions affecting the livelihood of hospital service providers.

Significantly revamping the operation of the Ontario health insurance plan, OHIP, including providing near total authority to the Minister of Health and cabinet to change and undermine the rules for payment and delivery of medical and other professional health services.

Granting government the power to unilaterally terminate agreements between the government and the Ontario Medical Association setting out representation, arbitration and other legal rights of physicians.

Introducing user fees under the Ontario drug benefit plan, which provides drug benefits for seniors and low-income individuals and families, as well as terminating the statutory bargaining rights of the Ontario Pharmacists' Association.

Legislatively imposing government-mandated criteria, such as the employer's ability to pay, on the interest arbitration process, thereby striking at the independence and integrity of the only method available to essential service workers for settling the terms and conditions of their collective agreements.

Eliminating the proxy method of comparison under pay equity legislation, which was intended to extend pay equity benefits to women working in certain female job ghettos.

Exempting many public sector employees from the protection of pension benefits legislation otherwise applicable in the case of significant downsizing.

Empowering the provincial government to restructure municipal governments, while at the same time extending to municipalities enhanced powers, including the right to charge user fees for municipal services.

Limiting access to records under freedom of information legislation.

Casey will speak from here.

Mr Casey Thomson: The full implications of the broad power granted to cabinet and individual ministers under the bill are difficult to assess.

Other schedules to the bill would enact various amendments to certain taxation, capital investment, toll highway, government borrowing, natural resources and mining legislation, as well as legislation requiring salary disclosure for employees earning over \$100,000 in the broader public sector and in non-profit private sector organizations which receive significant government funding. Profit-making private sector organizations which receive government funding would be exempt from this provision.

Bill 26 is an ominous bill because it is portentous of an unprecedented arrogance among our elected lawmakers. It not only assumes that cabinet ministers have a unique grasp of the truth and therefore should be empowered to override all skilled and heretofore legitimate authorities of the state, but that they are sufficiently superior in intellect, understanding and expertise to nullify awards, agreements and understandings made between agents of the crown, public servants, public agencies and the citizenry as a whole.

These suppositions are ludicrous and proven absurd by a simple review of the qualifications and experience of the various cabinet ministers. They have been elected to fulfil a political mandate, that is true, but that does not in any way imply that they have the requisite skills, ability or experience to dictate levels of service in the public interest absent the advice of those who possess real expertise and accountability.

Not only does Bill 26 bestow dictatorial powers upon ministers, it absolves them of all responsibility for making wrong decisions. They are saved harmless from the effects of their folly, while those to whom they have whimsically allowed some residual authority are now to be held personally liable for their decisions. No wonder

the government wants this legislation passed quickly without any meaningful legislative or public scrutiny.

Bill 26 is an act that legitimizes irresponsible, incompetent and corrupt government. It proposes no improvement to the quality or cost-efficiency of public services. It does not seek to serve the people of Ontario. Rather, it makes every activity of government subordinate to the desire to privatize services and cut the cost of people services. It replaces health care with wealth care. It seeks to make the corporate welfare bums of the Mulroney era the corporate wealth care barons of the Harris regime.

Consider: Stats Canada has shown that spending on social programs in Ontario is not out of control. Bank profits are at their highest in history, corporate profits are on a steep upward curve and yet none of these windfalls has been passed on to workers or to government to reduce the debt.

Why do we have a provincial debt? Experts argue that the state has the responsibility to develop social infrastructure. Roads, airports and public transit are just a few examples of projects whose cost is traditionally amortized over part of their long life expectancy. Taxpayers, both corporate and individual, therefore assume a long-term liability for a long-term sustained benefit. If we have roads, we can engage in industry and trade, and the wealth generated by these activities helps us to pay for our services. It simply cannot work the other way around. The horse must be in front of the cart and the cart must be on a navigable path before real progress can occur.

Debt by itself is not a bad thing and is sometimes absolutely necessary to move forward. Government decisions about the method of supporting or paying down the debt not only aspire to balanced budgets but ought to include fairly shared responsibilities among corporate and individual citizens.

Most CUPE members earning \$30,000 or less have received wage increases in the last four years which are far below the rate of inflation. Those earning \$30,000 have received no increases, and some employees, such as those in the city of Peterborough, are entering their sixth consecutive year without a wage increase. In the same period, the cost of living has climbed by over 14% and the real rate of taxation has virtually doubled.

Why should these poor, stalwart workers bear the incidence of the tax that attacks the deficit? Why should threats to this very subsistence be imposed upon the elderly, the infirm, the unemployed, the injured and the desperately poor? Social spending on their needs is a necessary contribution to continued civilization. To provide universally accessible health care, education, public utilities and social services are required to maintain safe, healthy and economically able communities.

Meanwhile, in the midst of these dark days for the workers and the needy of Ontario, banks and financial institutions are celebrating their biggest profits in history and major corporations are increasing profit-taking and are not sharing the benefits with employees.

We mourn the demise of government noblesse oblige, openness, integrity and democratic accountability. There remain things in life, in society, which are more important than money. If worse comes to worst, a debt can be paid tomorrow, but a life lost to a cost-saving decision can never be recovered.

No sector is more affected by Bill 26 than the health care sector. It will reduce the quality of care, demoralize physicians and all other health care workers, undermine the principle of universal access and regulate patient services on the basis of government whim rather than medical necessity.

Bill 26 does not attack overspending. It attacks the elderly, the poor and all who are in need of compassionate, high-quality care.

There are two big corporate winners if Bill 26 is enacted: foreign health care firms and multinational drug companies, but there will be 10,929,000 losers as Ontario's prosperous social welfare state devolves to a Third World marketplace.

For all of these reasons and those contained in the following appendices, we respectfully request the general government committee recommend that Bill 26 be withdrawn and that the reintroduction of any of its parts allow for full public hearings.

Perhaps those possessed with the greatest wealth could assist with the deficit and help Ontario break out of its downward recessionary spiral.

Cutting jobs, the effects on communities, means fewer services are available to the citizens of Ontario. But it also means less disposable income to support local businesses and therefore less revenue to small business to hire other workers and significantly less revenue returning to the Ontario government in the form of income and sales taxes. In fact, this generally explains the current phenomenon, that 10 years of persistent cutting of public services, public employment and social supports to needy people has had the effect not of generating savings but of actually increasing the deficit.

CUPE submits that a full employment policy is the only viable formula for eliminating the deficit and paying down the debt. We support a universally accessible health care, education and social service system which satisfies real human needs. We believe that those who profit most in society have a responsibility to contribute in a much more meaningful way to eliminating the debt and maintaining a high standard of living in the province that contributes so much of their wealth.

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Ms Boyd: At my workplace, privatization is a possibility because the funding to the municipalities has been reduced. Fairhaven has to try to exist with these cuts and provide an adequate level of care. I'm sorry, but I don't believe that an adequate level of care is appropriate. Quality service is what our residents require and deserve. These people are human beings, not machinery. When they require assistance, they expect assistance, not when we can get back to them.

Cuts in funding will result in cutbacks to staff, which will result in cuts to the services provided to our residents. Does the government believe that residents should sit in their wheelchairs or in their beds all day because the support staff are no longer there? Providing a minimal level of care is not the way I like to work, nor is it the way the elderly deserve to live the rest of their days.

Mr Thomson: As a hospital employee I have seen many drastic changes in the way care is given to the general public to date due to the enormous cuts to health

care already. Ontario now has a two-tier system in place; patients with money get adequate care, and those who don't, suffer immensely, lying in urine-soaked beds all night, being awakened at 4:30 in the morning for their daily bath, not being fed because they can't feed themselves and there is no one available to feed them due to the cutbacks, and that is before Bill 26 is in effect.

If this bill is passed I see the poor and slightly poor not getting the care they need and deserve. Deaths have increased and will continue to. Call bells will be answered less than they are now. Unqualified people will be taking care of our families and friends, all in the interest of money. Disease and serious illness will go undetected until it is too late.

This bill, in reality, will cost the people of Ontario much more, if not in dollars, then in deaths.

Mrs Hewitt: The effects of cuts to health care services rendered by an omnipotent minister will be devastating to those of us who live and work in the targeted community.

Essential health care services cannot be determined at arm's length merely by budgetary considerations by people who feel no sense of ownership to the community. The needs of the community are best determined by those of us who live and work there.

We understand the geographic, demographic and logistical problems, such as the lack of a public transportation system and the seasonal population fluxes, that impact on the delivery of essential health care services that in turn ultimately determine the wellbeing of our communities.

It is imperative that consultation take place with all of the stakeholders involved. Input from the service staff is as crucial as input from those who provide hands-on care, such as nurses and doctors. Indeed, it is all of these people who provide the delivery of health care in the homes and the hospitals.

Health care providers and health care recipients are a vital link in the restructuring process. We must not be shut out.

In closing we ask you, the committee, to recommend that Mr Harris withdraw Bill 26. Common sense must prevail.

Mrs McLeod: I'll just touch back on the very first page of your presentation and your comment about the democratic process and the desire of people to be involved. I think the size of the audience here tonight, sitting through these hearings, is an indication of how much people want to be involved, and those audiences have been growing every day this week as more people become aware of what this bill is and become concerned about it.

Thank goodness the bill didn't become law in December, because if it had, we would not have been here, able to hear from people from Peterborough and the district. We would not have had a chance to have your very thorough brief. You've done a fabulous job of analysing virtually every aspect of the bill, and I agree with your final recommendation that the bill should be withdrawn and any parts that are subsequently put forward should have adequate public debate.

I have to warn you that we haven't had a lot of luck getting the government to support our resolutions, but we'll keep trying.

One quick question, because there's so much ground you've covered, but maybe I'll take advantage of the fact that one of you is working in a long-term care facility: Could you just comment on copayment, the effect of copayment for drugs on seniors who are in a long-term care facility and many of whom are living with a comfort allowance that may be \$110 a month.

Ms Boyd: Quite frankly, it would probably mean the difference between eating and not eating. Does that answer your question?

Mrs McLeod: It does indeed. You know, we see \$2 and it doesn't look like a lot of money, but when your comfort allowance is maybe \$100 and that's all you've got for any of the extras, that means a great deal indeed.

Mr Marchese: Just a few quick comments and then a question, if I can. You made a comment around the banks and whether or not people like them are making their fair contribution to our economic deficits, and I can tell you they're not. It's interesting that 90% of what the banks invest is our dollars, not theirs; 10% is theirs. In Ontario alone, they control about \$155 billion. Most of that goes outside; some of it comes back and is loaned to the government, safely, at high interest rates. So imagine this: They use our money, 90% of it, to then lend back to governments, that then goes back to them as profits, and we pay for all that. It's an incredible thing. It continues to happen all over, in every jurisdiction, and yet we condone it, and we don't attack it enough. You're absolutely right. They need to pay their fair share.

You made another interesting observation. This bill alters the democratic processes to autocratic ones. You made the comment that this act goes far beyond the traditional ideology of the Conservative Party, and you're absolutely right. My accusation of them is that they're not a Conservative Party; at best they're a Reform Party, and at worst something else I dare not name. But what do you think are the values that underlie the printing of this Bill 26? What values underlie this bill?

Interjection: Great greed.

Mr Bill Nichol: I guess I'll answer. It is totally greed, in my opinion, and I believe among most people in this room it's agreed. It's also that there is no consideration for the everyday citizen in this province. They don't care about us as individuals; they don't care about their constituents; they don't care about anyone. The ultimate goal is to pay off the debt, and they don't care how many of these people in this room will not be working tomorrow morning to pay off that debt; it doesn't matter.

Mr Rollins: Thanks for your presentation. Just a few facts that I think you people may already have heard; I know some of the opposition have. They don't always remember what we say, but we don't always remember what they say either. There are 750 groups like yourselves which will have come to these hearings going on. There would have been 360 hours of hearings allotted for, had it gone on through the way it was. It's cut back down to 300 hours. Granted, the 360 hours were in Toronto.

If spending is the right answer and, according to you people, that if you kept on spending you could solve all the problems of the province of Ontario, in the last five years we went from a \$45-billion debt to well over \$100

billion; \$1 million an hour of interest. We may be interested in these people, but we're darned well interested in our grandchildren and our great-grandchildren not having to pay off the debt some of these other governments have had.

Interruption.

Mr Rollins: It's fact. There it is right there in fact. If those bills are not paid, it's a debt that we owe. We have a mortgage, and our obligation is to make sure that our grandchildren don't have that mortgage.

The Chair: Thank you very much. We appreciate your coming to us this evening and making a presentation.

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Mr Marchese: Mr Chair, I'd like to read a motion for the record, to be discussed now or later, according to your intent or interest.

Whereas there has been overwhelming public interest in Bill 26 and many groups and individuals have requested to appear before the standing committee on general government in Kingston and here in Peterborough, which far exceed the number of spaces available today for hearings;

I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged for the different communities;

Further, that this committee recommends that the three House leaders meet as soon as possible to discuss this issue.

The Chair: Thank you. I need a little direction. Do we take time away from one of the remaining presenters to debate this or do we defer it till next week?

Mrs McLeod: Do we have any indication that the government may vote differently than in the past?

The Chair: I don't think so. Anyway, we have to stop at 9 o'clock. We've got three presenters left, each with a half-hour; we're right on time.

Mr Marchese: Can we debate now, Mr Chair, as briefly as you would like?

The Chair: Would you like to take time away from one of the presenters to debate this?

Mr Marchese: Yes, I would, for one minute each.

The Chair: Okay, one minute.

Mr Marchese: Mr Chair, it's become apparent at every hearing that we've had that most groups wanted more time to understand this bill. Many people who have read it simply don't quite understand what is contained in it. The ones who have appeared before us understand the full implications of this bill and disagree strongly with its content because it will have adverse effect on the entire population of Ontario.

Keeping this in mind, it is my view that we need more time, that the public needs more time to assess what's here and that they need more time to be able to participate, not just the ones who appeared before us but those who have been unable to get on the list to participate.

Mr Clement: As we've said on numerous occasions, this committee process will have heard from over 750 presenters in over 12 cities in the province of Ontario. On both sides of the committee we are hearing a wide range

of views, a diversity of opinions, some critical, quite critical of the government, others supportive of what the government has to do. I can only say this to the mover of the motion: Our job is to be legislators as well as listeners. We have an obligation, when the debt is going up \$1 million an hour, when this takes money away from health care, away from palliative care, away from cancer sufferers and AIDS sufferers, we have a duty to act. The House leaders agreed to act on January 29. NDPs, Liberals and PCs agreed to that. I intend to stick to that agreement.

Mr Miclash: Mr Chair, I'll certainly be supporting the motion as well. What the motion has actually done is it's brought forth an indication of the concern and the interest in this piece of legislation. As we move from city to city, my leader indicated earlier, we see the crowds growing and the concern growing over this legislation.

We had a professional in this room this evening who said he read it and only understood one third of what was in the particular legislation. I must say that as I listen to the groups, as I listen to those who are not able to present their views and their concerns, I truly think we have to put this back into the House leaders' laps and have them take another, closer look at the decisions made after noting the overwhelming concern about this legislation.

The Chair: Those in favour of the motion? Those opposed? The motion is defeated.

PETERBOROUGH CITY RADIOLOGISTS

The Chair: The next group to present is the Peterborough City Radiologists, represented by Dr David Swales, who is a radiologist at the Peterborough Civic/St Joseph's Hospital. Good evening, Doctor. Welcome to our committee. You have 29 minutes to use of our time.

Dr David Swales: Thank you for allowing me to make a presentation to your committee. I'm a medical specialist in diagnostic imaging. I'm speaking on behalf of the radiologists who service 10 hospitals in six different counties in this region, as well as a number of independent health facilities in four counties. The hospitals are Peterborough Civic Hospital and St Joseph's Hospital in Peterborough, Port Hope and District Hospital, the Cobourg District Hospital, the Ross Memorial Hospital in Lindsay, the Minden Hospital, the Haliburton Hospital, the North Hastings District Hospital in Bancroft and the St Francis Memorial Hospital in Barry's Bay, so I truly represent rural radiology in east central Ontario.

This is a difficult environment for a high-technology service, as the escalating costs of the technology create a significant burden for small, rural hospitals. By working together cooperatively as radiologists in these institutions, we have tried to maintain a high quality of care.

Bill 26 has some significant recommendations that will make it increasingly difficult for us to maintain our standard of care. Some components of this bill are helpful, but I shall dwell upon the parts that potentially will harm the quality of care we deliver.

The first deals with the Public Hospitals Act amendments. Bill 26 gives extraordinary powers to the local hospital administrators and boards to unilaterally eliminate services and to revoke physicians' hospital privileges

without right of appeal. This destroys the healthy balance currently in place between physicians and administrators. In my experience in this community, the physicians have been very strong advocates for the patients. The administrators and boards have a mandate to look after the welfare of the institutions. Their authority does not extend beyond the walls of the institutions.

The roles of the physicians and the administrators oftentimes come into conflict. However, currently this tension can be useful, with the physicians bringing the patients' concerns forward and the administrators bringing a sense of fiscal reality to the discussions. If this balance of power is destroyed, as proposed in this bill, then the voice of the patients will be silenced. Physicians won't wish to risk revocation of their privileges by speaking out. A better solution would be to give the community input into major changes of health care delivery.

Currently, the addition of a new clinical service in the community requires support from the district health council. Conversely, I would propose that the elimination of any clinical service similarly would require approval by the district health council.

Hospitals have the mandate to terminate a physician's privileges for quality of care issues currently, and that should remain so. However, the termination of specialist privileges for other reasons should require approval by the district health council as well, as this would affect the range of services available in the community.

This is not just a theoretical consideration, as we've had such an event here in this community, and this happened during my term as chairman of the local district health council. The Civic Hospital here in Peterborough ended the diabetic day care program unilaterally without any public or community consultation. We tried unsuccessfully at the district health council, after the fact, to have someone else pick up the service, but to no avail. Thus these vulnerable patients were set adrift without access to proper nutritional counselling etc.

There must be community safeguards in place to prevent a repetition of such actions. From my experience at the district health council, we have a body already in place with conscientious and knowledgeable community volunteers. In fact, I have talked to them about this off the record, and they would be willing to take on this role as they see it very similar to their current role for approval of new services.

This bill, as currently written, does not have these community safeguards in place. Please don't give this authority to the hospitals. They are not the right body to exercise this mandate.

The second point is the Independent Health Facilities Act amendments. The Ontario Association of Radiologists has a very good track record in working with the ministry in developing the ground rules for independent health facilities and, in particular, in developing standards for assurance of quality. This control of quality is achieved through monitoring other radiologists by the College of Physicians and Surgeons of Ontario. Failure to maintain standards of care is accepted and supported by the radiologists as a legitimate reason for a revocation of an independent health facility licence.

Bill 26 allows the ministry to revoke a licence without right of appeal. The capital costs of equipment for an

independent health facility are very high. For example, if I take the major independent health facility here in Peterborough, it has a replacement cost of approximately \$1 million for its equipment. One really needs a stable environment to invest these sorts of dollars. The potential for revocation of a licence by the ministry, even with verified high quality of care, will lead to the use of old and older equipment with no reinvestment in updating equipment.

In Peterborough, this particular independent health facility is not a duplication of services. It is the only local facility to perform nuclear medicine spec scans on the heart and skeleton. In fact, the presence of this service is taken into account in the planning of the local hospitals. The planning of the hospitals and this independent health facility have, in effect, become integrated.

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We must have a stable environment to allow us to upgrade our technology and properly serve the community. Thus, I would propose that the revocation of an independent health facility licence should continue to be based only on the quality-of-care considerations and with due process.

Currently, a request for a proposal for a new independent health facility is an open bidding process. Bill 26 would allow the ministry to preselect applicants without public consultation or disclosure and one could see that this would have the potential for all sorts of abuse, and thus, I would suggest that this amendment be reconsidered.

Thirdly, for the Independent Health Facilities Act, Bill 26 proposes to remove the preference for Canadian applicants seeking a new independent health facility licence. This opens the way for large American corporations to replace the local radiologists. It is difficult to see how the ministry could enforce the current level of quality assurance on an out-of-country, non-physician owner. This should be reconsidered as well.

Physician distribution: Physician recruitment to this area has been a real problem in recent years. Psychiatry and family practice are prominent examples that have received a lot of publicity and will be dealt with by others. Radiology has not made the headlines, but we too have had significant difficulties. We have been attempting over the last three years to recruit radiologists to replace retiring partners. We have not been able to attract a single body from the five training programs in Ontario. I'll elaborate upon our experience.

We had a number of final-year residents who would visit us and three seriously considered Peterborough. One was offered a position in Colorado with access to all the latest technology and he subsequently moved to Colorado. Another was keen to come to Peterborough, but her husband was a teacher and try as I might, I could not find a job for him in the Peterborough area and so she also left and went to the States. The third possibility had a lawyer husband whose area of practice required a large urban setting, so she ended up practising in Toronto.

Our experience verifies some excellent investigative reporting that was done a couple of years back by the Peterborough Examiner when the problem of obtaining

family practitioners really became a big public issue here. They interviewed family practice residents in Toronto and found an overwhelming majority were going to stay in Toronto. The dominant reason was spousal employment.

We finally got our new radiologist by getting one into Cobourg and Port Hope via the underserved area exemption, as he had trained out of Ontario and was from the University of Manitoba and otherwise would not be allowed to practise in Ontario. Our other two recruits were established radiologists we were able to lure away from other communities, so we would cause a void in those communities.

This is a very difficult problem. There is a maldistribution of physicians in Ontario, as has been well-documented, and although it is not as great for radiology, it also exists for that, our specialty. Thus, this has to be addressed. In the short term, ideally we would need incentives for rural practice, but if they don't work then I think we have to have deterrents to new practices in large urban areas. In the longer term, I believe we should set aside spots in Ontario medical schools for rural students, in exchange for a guarantee of setting up practice in rural areas. This is something that was recommended in the Barer-Stoddart report, which some of you may be familiar with.

I also have concerns about the risk of patient confidentiality contained in this bill, but this has been dealt with by previous speakers and also will be dealt with by subsequent speakers, so I won't duplicate that.

Finally, I would like to say that the physicians, for the most part, want to deliver good quality care and to be advocates for their patients. This bill, by eliminating formal consultation with the physicians, is squandering a very valuable resource in this province. Surely, a partnership between the government and the various health care providers is the way to go in this time of fiscal restraint. Thank you.

Mr Marchese: Dr Swales, I think you might have mentioned one thing that I understood that you liked of the proposals they've introduced; I'm not quite sure. Is there anything in here that you've read that you agree with or like, for whatever reason?

Dr Swales: There has to be some assimilation for the continued restructuring process. I'm disturbed by the centralizing trend of this bill. The district health council would be a very valuable asset in this area. The idea is good; I'm not sure the means is the correct one. Certainly we in this area feel we would like to have more local input into how health care is delivered in this region. There's always a suspicion that Queen's Park doesn't understand our needs.

I can illustrate that by the original document I got for this particular committee: It was to wind up at 12 o'clock at Kingston; you were to have your lunch, get on the bus and be sitting here at 1 o'clock in Peterborough. It implies that the people in Queen's Park don't even know where we are, let alone what our potential needs are in health care.

Mr Marchese: You were saying that if you couldn't get doctors to voluntarily come to some areas you might need some deterrents. I'm not sure you agree with what they're proposing. I find them autocratic, intrusive and

draconian. I don't believe government should behave in that way. We've got to find another way to deal with our problems. If this is the way we're doing it, it's wrong. I'm assuming you agree.

Dr Swales: I'm saying that's the second choice, but we have to deal with that problem. The first choice is to try to make it more enticing to go to the rural areas. We do have a real problem, and it has to be addressed.

Mr Marchese: I understand that. I don't think this is the way to do it. My view is that the health care providers and health care users have not been consulted at all in the preparation of this bill, and that's a fundamental flaw. That's why we're seeing a lot of people today and from other parts of the province coming to these committees saying they disagree with much of what they have seen, heard or read. I believe that when you don't consult people, ultimately you're going to have something they will disagree with, that won't work.

Dr Swales: I would agree with that, yes.

Mr Clement: I want to thank you for your very thoughtful presentation. You can be assured that all the members on the government side will take it seriously. I note that none of us on this side represents Metropolitan Toronto ridings, so we're inoculated from that particular problem you mentioned.

You mentioned in your response to Mr Marchese that there is a centralizing trend in the legislation when it comes to hospital restructuring, I guess in terms of the hospital restructuring commission, but that the district health council should be the way to start in terms of getting the local input and analysis and planning.

We've had a lot of submissions from local DHCs and hospitals over the past few weeks, saying: "We know we're going to be there analysing the situation, planning the situation, but ultimately someone has to decide. We don't have the power in the local community to come to an agreement when there is perhaps paralysis in the community or a very bipolar situation where you've got two very different points of view, or even more than two points of view. Somebody's got to decide. It's got to be the Minister of Health or his delegate." Is that a fair tradeoff? If, as the minister has already stated, we sunset those powers after a period of time, do you think that's a fair tradeoff?

Dr Swales: I think a mixture of the two, I certainly agree. I've had experience: I chaired the restructuring committee between Port Hope and Cobourg, and Dr Galt will know that was a very difficult issue and has just been resolved, I think to everybody's satisfaction, but it was a real struggle. The government does have to do some nudging, but a lot of the groundwork should be done locally, as was done in that case. It's not easy and it certainly wasn't easy there on the lakeshore, but ultimately we did receive the results.

Mr Clement: I think that's a very good way to put it, sir. I might also parenthetically mention that DHCs are still enshrined in the act. They are not mentioned in Bill 26, which means they're not changed; their powers of analysis and planning are still found in the original act and will not be changed. If there's a way to tie that in and perhaps make that more explicit, that the restructuring commission does take in the information, the planning and analysis from the DHC, would that satisfy you?

Dr Swales: That would certainly be helpful.

Mr Clement: Let me talk a bit about the independent health facilities, because that's another area of concern you raised. You mentioned that you're familiar with and support the request-for-proposal idea rather than the minister having the authority to designate new independent health facilities. I have a constituent in my riding who has been waiting for four years now for a reply to his RFP, which indicates to me that the system may not be working as efficiently as it could. He wants to offer more medical services in my community but he has not found a way to break the logjam in the system. Given that kind of context, do you think there's a way we can improve that?

Dr Swales: I would think the fault lies with the ministry. The ministry should be able to deal with those in a swifter fashion.

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Mr Clement: They get logjammed at the local level, though, because they go to the DHC, from what I understand.

Dr Swales: With a good DHC, there shouldn't be a logjam at that level.

Mr Clement: We'll keep working on that one.

Let's talk about underserved and overserved areas, because that's something we've heard a lot about in northeastern and northwestern Ontario as well. I just want to understand completely what you're saying. You're saying, if I can paraphrase—and you can agree or disagree—that you would prefer there be a negotiating process involving the doctors, the community and the ministry, but ultimately, given that we've been negotiating for two decades now—the Liberal government's negotiated, the NDP government's negotiated—there has to be some authority of the minister to break the logjam. Is that a fair analysis of what you said?

Dr Swales: Yes. The problem is that we keep changing the negotiating teams. The government is changing, so we start over again. There hasn't been a continuum in negotiations, because they've stopped and started again with a new organization. This is one of the big problems, that there hasn't been continuity on the government side.

Mr Clement: Our government has accepted incentives and acknowledged that there has to be a process for the education of general practitioners and persons who are in medical school. But ultimately, if all that breaks down and we have a two-tiered medical system developing whereby some communities have doctors and other communities don't have doctors, the government, as the custodians of the public, has to act. Is that a fair thing?

Dr Swales: Ultimately, if we fail on the incentive and encouragement end of it, and possibly restructuring the admission pattern to medical schools, the government has no choice but to step in in that circumstance. But we want to give it a shot first before we bring in that sort of thing.

Mr Michlash: I appreciate your comments about Peterborough and Queen's Park. Try to get Queen's Park to realize where Ear Falls is and you've got a real challenge.

I'm interested in what you're saying in terms of the attraction and retention of health care professionals into

underserved areas. You talk about the long term and the short term to alleviate the problem. I agree with you that it's going to take negotiations between the government and new people coming into the field; the OMA should be heavily involved. Do you have any particular solutions you would like to put on the table today? You mentioned a number of problems, but I'm wondering whether you have any solutions.

Dr Swales: The selection process into medical school is a critical one. If you're selecting students from an urban background, the chances of them wanting to go to a rural setting are much slimmer than if you choose students from a rural background. From my own family, one of our children is in medicine and he is practising in a small community because he came from a more or less rural background and enjoyed that way of life and has gone back to that setting. I think that truly does work. The biggest problem, as I see it, is that you want to be sure they don't marry someone with an urban occupation. I don't know how you beat that.

Mrs McLeod: Before we leave the issue of more positive alternatives to billing numbers, as northerners, Frank and I always like to recognize the fact that there are success stories. The Family Medicine North program has a retention rate of 67% of people training in that program, and I think some of the proposals for rural training residencies would have the same kinds of retention rates.

I want to come back to the Independent Health Facilities Act and our frustration with the act. It touches so many areas of concern; each of them needs individual debate, and you've raised a number of them. The Independent Health Facilities Act is one we've not had a lot of time to talk about. I thought that's where Mr Clement's question was going, because he raised it initially under independent health facilities and then got talking about a local problem. I hope he doesn't see independent health facilities and new facilities as being a way of getting around district health council planning, but I'll let him speak to that.

Do you find it strange and can you think of any reason why, even with a government prepared to shift some services to independent health facilities and to open new facilities, to take away the Canadian preference, there would not be a request for a proposal? Wouldn't any government want to get the best proposal for offering a service in an independent facility?

Dr Swales: This is certainly what I was proposing, that it be an open process. Presumably, the selection would be on the basis of the quality of the proposal.

Mrs McLeod: Yet in this legislation, the ability to determine who would operate an independent health facility is left entirely to the minister, without a request for a proposal.

Dr Swales: That's my understanding, and I think that's a dangerous plan. I hope none of you are from the Maritimes, but it happens with the post office in Nova Scotia that when the government changes, the postmaster changes. You could see the same sort of thing happening in independent health facilities, but you have a big investment in these facilities, and that's frightening.

Mrs McLeod: One of the other things the act does in relationship to independent facilities is give the minister

the power to say what new services can be offered out of independent health facilities, which are currently often hospitals. Is that an issue you think we need to be concerned about and need to be on guard with?

Dr Swales: I don't have the same concern with that, particularly. My big concern from the community's point of view would be that the service, if it's dropped from a hospital, is available in that community. Particularly in this area, in the four counties we serve, we have a disproportionate number of seniors, and travel can be a very difficult thing for seniors. Ideally, we should be able to deliver the services as close to home as we can. In Peterborough, we're more or less integrating the planning of the independent health facilities and the hospitals, and I think that's the ideal.

Mrs McLeod: So the withdrawal of Canadian preference might be a somewhat greater concern in terms of the long-term implications.

Dr Swales: Yes.

Mrs McLeod: One of the things we heard in Ottawa yesterday was that physicians in Ottawa are already hesitating to make decisions about testing because of the climate that's now being created about physicians being second-guessed by the general manager of OHIP. There are probably 10 seconds left, if you'd care to comment on whether you see that as a danger or even some of it happening now.

Dr Swales: It is a danger. I can't speak to it, because I don't self-refer; we have strictly a referral practice. I can speak to it secondhand, that it is a big concern among physicians in Peterborough. A brief will be appended to one of the presentations by one of the local neurologists dealing with this particular issue. I think it is significant.

The Chair: Thank you very much, Doctor. We appreciate your presentation.

RENFREW AND DISTRICT LABOUR COUNCIL

The Chair: The next presenter is the Renfrew and District Labour Council, represented by Robert Patrick, who is a member and an ambulance officer. Good evening, and welcome to our committee.

Mr Robert Patrick: I'm very happy and surprised to be here, and I want to thank the opposition for this opportunity—surprised because page 7 of the Common Sense Revolution says health care spending won't be touched. On page 17 Mr Harris says that he appreciates the expertise that's in the Ontario Public Service Employees Union and he would look forward to soliciting our ideas and working with us. I never dreamt this was going to be the forum in which I would be expressing my ideas. So much for my prologue.

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I'm an ambulance officer and I'm with the Renfrew and District Labour Council. The Renfrew labour council is very concerned about health care in Renfrew county and in the adjacent counties. The catchment area for our medical facilities and related services—health labs, nursing homes, hospitals and ambulance services—is very expansive and undefined.

Our medical facilities serve a geographical area stretching from Ottawa to Mattawa, from the Ottawa

River to Highway 7. This includes communities such as Arnprior, Renfrew, Pembroke, Petawawa, Deep River and Chalk River on the north to Smith Falls, Perth, Callander, Madoc and Peterborough on the south. Within these boundaries are found communities such as Eganville, Barry's Bay and Bancroft, just to name a few. We're looking at a geographical area of approximately 850,000 hectares, with a sparse population of 150,000 people. These people deserve health care.

We feel that Bill 26 threatens the very existence of our already meagre health care infrastructure and the services that are already having difficulty attracting health care professionals: doctors, therapists and the likes of those people. Bill 26, I believe, will exacerbate this situation, mainly because we're not considered north and we're not considered south. We're in that no man's land somewhere in between. The bureaucrats in Toronto think Barrie is north, so I don't know what they think about Renfrew and Bancroft and those places.

The obstetrical delivery systems are being curtailed and centralized. Hospital labs are operating at a fraction of their capabilities and are not allowed to compete with the private for-profit, more expensive health care labs. The profits of one private health care lab, MBS, increased from \$1 million in 1994 to \$33 million in 1995. That money came out of OHIP, I suspect.

As an ambulance officer, my personal interest is in the future of the ambulance delivery system not only in rural Ontario but across this province. For the past 20 years my colleagues and I have fought to improve the ambulance delivery system and the level of care and treatment that we can extend to the sick and injured citizens of Ontario. I fought three successive governments, and I mean fought—it has been a struggle; I have become apolitical as a result of it—I don't know, about seven Health ministers. It has been very, very frustrating, and now we're threatened with privatization.

I remember when ambulance services were run out of funeral parlours, service stations, furniture stores, taxi companies. I remember when competing ambulance services fought over their patients on the streets of Ottawa. They'd fight over their patients. They'd sabotage each other's vehicles because they were paid by the patient carrying call.

Probably one of the main strengths of our existing present ambulance system is the fact that there are no boundaries. Back in the days of the private ambulance operators, pre-government involvement, private operators established what can best be described as elastic boundaries, influenced by the nature of the call, their current call volume, the availability of staff and greed.

In spite of the advantages that have been made over the past 20 years, the present cost of ambulance delivery system is still less than 2% of the total health care budget. I'm heartened by the minister's announcement that this government is willing to inject \$15.5 million into the system and make paramedic ambulances a reality.

But if this money is spent and then the ambulance delivery system is turned over to the private sector with all its inherent problems, we will have achieved nothing, as I believe it will self-destruct. Bill 26 gives the minister the autonomy and the authority to make that decision,

and I mean the decision as to whether to privatize or not. We know Laidlaw is sitting on the sidelines, just waiting to swoop in, and we've had a very good illustration in Ottawa of what Laidlaw will do.

I believe that a vibrant, viable ambulance delivery system is one of the cornerstones of a credible, effective health care system. The present trend to hospital downsizing, closing of emergency facilities, centralizing of obstetrical delivery units, cardiac and cancer units, the total closure of some hospitals and the ever-increasing volume of patients being treated at home make it imperative that the ambulance delivery system be there and be dependable.

I have seen expectant fathers burn out their motor rushing to the hospital in Renfrew because the ambulance was in Ottawa. I've seen parents of children driving to Ottawa at 100 mph on the highways because there was no ambulance. On a night call, when I'm working night shift and I go to Ottawa, there isn't an ambulance from the city of Ottawa to the city of Pembroke. That's 100 miles of Highway 17 and all the communities in between. There is no ambulance coverage for them. We're playing the law of averages, hoping that we don't get a call.

I've struggled and fought—not only me; there has been a group of us on both sides, the labour side and the management side, and even within the ministry—against the bureaucrats and the politicians to get improvements. Here we are on the threshold of a paramedic ambulance service and the whole thing could be for naught, if it gets privatized to somebody like Laidlaw.

Over the past several years, the present Ontario system, with all its warts and wrinkles, has been studied by other jurisdictions—provinces and states—as a model they would like to adopt all of or some of.

My presentation is very brief because I have not read Bill 26. I've read synopses of it. I've followed it in the newspapers. I've opinions and thoughts on several aspects of it. But the thing that's near and dear to my heart is ambulance. I'm 55 years of age, I'm two years away from my retirement and I could be gone this week, next week. The minute the minister decides he wants to privatize my ambulance service, under Bill 7 I'm history. I tell you what: It's a very discouraging outlook, after dedicating 22 years to this and seeing the advances that we've made, to see the whole thing go down the toilet.

Mr Doug Galt (Northumberland): Thank you very much for an excellent presentation. It's kind of refreshing to have a nice brief one.

Mr Patrick: It's right off the top of my head because it's a gut feeling presentation.

Mr Galt: We have a budget of \$17.4 billion. That was what we promised in the campaign, a closed envelope, and that we would try and do our very best within that to make it as efficient as we possibly can. It's over a third of the spending budget of the Ontario government. The fastest-growing portion of the budget is interest, that is, the interest piece of the pie is what's growing the fastest in our budget, and we're frightened about that.

It's now 18 cents on the tax dollar. If we don't do something, if we remain the status quo, the way we've been running the last few years, it'll be closer to 40 cents on the tax dollar, and we're very, very concerned as to

what our grandchildren are going to inherit. That's the premise we're coming from and struggling with, and regardless of where we turn, we find that those are not the right possible areas to be cutting. People are concerned about various reductions.

Having made those introductory comments, one of the examples of growth that you should be aware of, and it hasn't come out earlier this evening, is in the Ontario drug benefit plan. It started out 10 years ago at about \$400 million; it's now \$1.2 billion. It has increased three times in 10 years. That is the kind of thing that happens when you start giving something totally free, and it's of concern when you see it going at that rate. Something has to be done.

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We're committed to try and reinvest, reallocate, and that's where the paramedic training has come in that you made reference to. I, for one, think it's a great service, a great idea. I'm like yourself, a similar age, and I do remember when ambulances came out of service stations and came from the funeral parlours. I kind of wondered if there was a conflict of interest when they came out of funeral parlours.

Mr Patrick: Some of them definitely had, I'll tell you.

Mr Galt: No pun intended there, but you really did have to kind of wonder about it.

You've mentioned the concern about privatization of ambulances. Do you have other suggestions of what we may do in the ambulatory area of service, keeping in mind the concerns that we have with these dollars?

Mr Patrick: I would like to see the ambulance service, as I say, with all its warts and wrinkles, remain pretty much as it is. There are areas that can be improved. There are governance areas that can be touched up. Educating ambulance officers and training them after employment is a terrible waste of money. Like in the paramedic field, you get hired as an ambulance officer and then you go off and learn to be a paramedic. It costs the employer \$50,000 to train a paramedic.

There's no reason why paramedics can't be in the college system the same as a nurse. It could be a two-year program or even a full one-year program of ambulance officer and then the second phase would be a paramedic. They'd be coming to the employer with their credentials. "I am a paramedic." Then it would be up to the hospitals, the base hospitals and the doctors in those base hospitals, to make the quality assurance things that they're doing anyway.

But right now, and Ms Grier can certainly attest to this, the cost right now, we have a desperate need for paramedic ambulance officers on the aircraft and we can't get them. We can get them, but the employer is not willing to invest \$50,000 into somebody who after they get the job may go and work in Metro or Hamilton. They're not going to stay up in Timmins and Sioux Lookout and those places when they get to be paramedics.

It has to be a pre-employment, and there's an evolution that's going to have to take place. It could take, say, five years to get that program into the schools. It should have been in the schools last September, because we certainly have been consulted and expressed those opinions. But

that's just one area right off the top of my head I can tell you where we could save some money in ambulance.

Mr Galt: I think it's important that we talk to people in the field like yourself, talking with a separate school board recently trying to find out from them, "Where are your extra dollars?" Through the planning of secondary school teachers in that board \$5.5 million is spent. Every two years we could build a school from those dollars.

Mr Patrick: We have ambulances sitting in the same communities today that they were in 30 years ago. In some places we've got ambulance services 10 miles apart, some even closer. They should be redistributed and moved into the different communities.

Mr Galt: Should they go out from the hospitals?

Mr Patrick: No, because you're bringing the patient to the hospital, and this is a fallacy too. Hospital-based ambulance services are somewhat contradictory in this sense. Now, there are a lot of interhospital transfers. But we just moved into a new ambulance facility built by our hospital in their front yard. We used to be at the other end of town, which made more sense. It got me to that call faster because I was closer to the call when I started out.

Mr Galt: Can we just change a little bit from your bringing patients into hospitals into the area of restructuring? Over this last term of government we've reduced the number of acute care patient beds by 6,700, which is equal to some 30 medium-sized hospitals. We're trying to get more non-political by this new commission that's being placed in Bill 26 to try and come about having some of these hospitals close. Just having 6,700 empty beds and empty rooms is not saving very many dollars. You're still heating the hospital and making it operate. Do you have any thoughts on getting these hospitals restructured?

I'm coming from an area where there are two hospitals about six miles apart and, as mentioned by Dr Swales, the two boards are now working together. They're amalgamating their boards, their services. That's going very, very smoothly and I'm just thrilled about it. Do you have some thoughts on this commission and giving some teeth and getting it out of the politicians' hands so that it would be a more neutral body?

Mr Patrick: It would be a neutral body, but my concern about them is who are they accountable to? If they don't make the sorts of things the local communities support, who do they go after? Who would be accountable in the final for the decisions that are made by these people? Do you say, "Oh, they made a bad decision; we're going to take them off the commission and put somebody else on," and that will solve the problem? No, that doesn't solve the problem because the decision was still made.

Mr Miclash: Mr Patrick, thank you very much for your presentation. I think this is the first we've had from somebody in the field of the ambulances and representing the ambulance workers across the province. I notice that you're from Renfrew District Labour Council and you quoted a couple of comments from the Common Sense Revolution going back to consultation. The question I've been putting to groups such as yourself and to groups across Ontario as we've travelled is the fact that I don't

believe there was any consultation in the drafting of Bill 26. I would just like to know if you know of any consultation in the actual draft of Bill 26. Were you or your council consulted in the actual draft?

Mr Patrick: No, to my knowledge. I suspect there was consultation, but it certainly wasn't with the communities at large. I believe it was with people like the vice-president of the Bay, Liberty, London Life, IBM.

Mr Miclash: I have to agree with you because we haven't met with any of those folks yet to ask them.

Mr Patrick: You won't see them coming before the panel. I'll guarantee you won't. They've had their say.

Mr Miclash: We're certainly hearing the same thing from folks such as yourself.

In terms of the delivery service, you were indicating that it's 2% of the total health care budget, and you indicated that the ambulance delivery service and the system is the cornerstone of delivery of good health care. You've alluded to a good number of points that privatization would have an effect on this particular service. I would just like to again thank you for getting those on the record and hopefully we'll have some results from what you've indicated here to us today.

Mr Patrick: If I may volunteer something just for a moment that the doctor before me sort of addressed, there's another area where I think we could make the service a little better, if we get nurse practitioners and paramedic ambulance officers working in emergency units, such as Barry's Bay or Bancroft or even in some of the larger communities, because you don't have to have a doctor for everything that comes into that emergency department. You could supplement the doctors with the people who certainly have the skills and the knowledge to treat the fractures and the scratches and the lacerations. Hey, a nurse can stitch you up as good as a doctor can and in many cases the nurse is the one who ends up doing it.

Mrs McLeod: I'm just wondering whether or not you as an individual citizen concerned obviously about health care is starting to feel as frustrated as I am. Maybe it's just because it's Friday night and I've been in hearings all week long, but I hear the government lecturing us about how all of this bill and all of its powers and all of its changes to health care are necessary because, after all, the debt is growing at \$1 million an hour. I don't yet understand, having heard that lecture I can't tell you how many times, every day this week, why it makes sense then if you're worried about the debt growing, to put \$5 billion more into the problem by giving that income tax break to people. I see that income tax cut driving the level of cuts that this bill is all about, and make no doubt about it, this is about cutting health care.

I notice Mr Galt saying that people are very concerned about reductions, that times are tough and everybody's going to worry about reductions in every area. I think people are worried about reductions particularly when it comes to health care, and I think they're worried about reductions in health care, cuts in health care from a government that said it wasn't going to cut a penny in health care and is cutting \$1.5 billion. I want to ask you, as a private citizen concerned about health care, how you feel about cuts in the health care system.

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Mr Patrick: I support cuts in some areas of it. The drugs, Mr Mulroney's drug patent act that allowed drugs to skyrocket: When I go and pick up a little old lady, 77 years of age, with an overnight travel case this big—I'm not exaggerating—full of drugs—the doctors will prescribe a drug for you and you go home and you have a reaction to it. Guess what? They say, "Don't take that drug any more, here's another one."

All of a sudden, you've got a cupboard full of drugs. You can't take them back, you can't refund them. They just keep issuing more and more. I see this in the nursing homes, I see it in the private homes I go to. Drugs to me are one of the greatest drains on OHIP going because of the proliferation of them out there, and as I say, if you have a reaction to it, you can't throw it in the garbage, so they give you another prescription.

Mrs McLeod: Exactly. It's interesting you raise that because we've had a number of presentations from people who are concerned about utilization of drugs but don't think that copayments and the government getting information about individuals' health records is the way to control it. One of the things that's interesting, because you talk about the wastage, is that about 15% of the increased use of drugs is because of large volumes of prescriptions, that drugs should be prescribed in smaller volumes so that seniors won't be taking more or wasting more.

Mr Patrick: Drug overdoses among seniors is one of our more common calls, especially in the wintertime when it's dark earlier in the day and their eyesight is not as good.

Mrs McLeod: The point I was going to make was it's ironic, because one of the effects that this copayment will have is that because people will be concerned about charging the copayment too often to seniors, they're going to prescribe drugs in larger volumes at once so they don't have as many copayments. I think what you're just describing is going to get worse rather than better.

Mr Patrick: Or the senior will say, "I can't afford to buy my drugs this week," or this month, and they won't buy them. They won't go and get them because they can't afford the copayments.

Mr Marchese: I agree with you with your fear about privatizing ambulance services and what that would mean to the workers and to our citizens. My hope is that this would never happen. On the other hand, I would be very vigilant; you never know.

It's important for governments to consult. We certainly did a lot of that when we were in government. Some claim we did too much. We did plenty of it because we felt it was important to hear all the sides. When you do that, you get attacked on all sides, both from your friends and from your foes. We have an obligation, however, to do so. They were almost successful in having no consultation whatsoever, which I think is the worst thing any government could do in a democratic society, so it's good to have people like you here. I hope you will keep an eye on what this government is going to do. They will continue to introduce bills with very little consultation and the only way you will hear about it is by staying tuned or keeping in touch with some member who is

likely to give you information as to what is happening. I appreciate your presentation and hope you will continue doing that in the future.

The Chair: Thank you, sir. We appreciate your presence here tonight and your interest in our process.

Mrs McLeod: Mr Chairman, I note that the Northumberland Community Coalition is one of the groups that was not able to make a presentation this evening. They have tabled a written brief and I'm just wondering whether or not that has been noted for the official record.

The Chair: Everyone has a copy? Okay. Thank you.

PETERBOROUGH COUNTY MEDICAL SOCIETY

The Chair: Our final presenter for the evening and for the week is the Peterborough County Medical Society. Thank you very much for being here. We appreciate your attendance. You have a half-hour to use.

Dr Marshall Trossman: Thank you for the opportunity of appearing before you. My name is Marshall Trossman. I come here as the president of the Peterborough County Medical Society, which represents some 200 physicians in this area. I'm joined by two of my colleagues, who will introduce themselves.

Dr Carlo Bos: My name is Carlo Bos. I'm a fellowship obstetrician and gynaecologist practising here in Peterborough and I represent my four colleagues in the submission to the committee.

Dr John Gray: My name is John Gray. I'm a family physician of 21 years in Peterborough. I was president of the Peterborough County Medical Society in 1980 and I'm currently chair of the board of directors of the Ontario Medical Association, representing the Ontario physicians on the board of directors of the OMA for this area.

Dr Trossman: I am a semi-retired family physician. I have been involved in medicine for over 50 years, 24 in this community. As I said, I speak on behalf of the county medical society.

It must be clear to the committee that the local doctors, as other members in the province, are concerned about Bill 26. An initial reaction of anger has been followed by anxiety, discouragement and disappointment. About whom? Not ourselves alone, as comments from government have implied, and indeed we deplore the argumentative and pejorative comments that have been made about physicians and have been attributed to the Minister of Health. We are concerned for our patients, the public, our community and for the health care system.

Irrespective of the system of health care delivery—I have seen a number of these—the primary concern of a doctor is for the wellbeing of his or her patient. The relationship between a patient and a doctor may range from being episodic and transitory to one that is lifelong and involves intimate details. It is one wherein a patient confides details of his or her life that are not released to anyone else. Would any person want this information conveyed to an unknown official for fiscal reasons?

But this is one aspect of this bill which could occur. Patient records could be examined without the patient's permission to determine if a "medically necessary" treatment or test was ordered. Do you want a faceless bureaucrat looking at your doctor's records of your case,

knowing everything about you, and deciding if you had appropriate treatment? I think not.

I referred to the patient-doctor relationship, one which takes time to develop and longer to last. What if the doctor cannot remain in that relationship? This does occur, of course, due to death or retirement or a move to another community. But the provisions of this bill, or the implications related to it, may lead to government intervention. A doctor may be deemed to be superfluous to his or her community because it is overserved, this by government decision, or else a specialist may be refused a hospital appointment, often for financial reasons, and so would be denied the right to bill and therefore be denied the right to continue to practise. What if the government decided that a doctor is "too old" to practise and terminates his billing number? What would that do to the patient-doctor relationship, to the continuity of care to the public?

I assure you that one comes close to my heart. I find it passing strange that the princes of the church and the justices of the Supreme Court may continue their function until 75, but a doctor may not be allowed that option.

Maldistribution of medical services has been referred to: not enough doctors in rural areas. This is a problem faced by many communities, this one no less. The bill proposes to remedy this situation by forcing doctors to go to these rural areas, essentially by not allowing them to practise in larger communities because they are dubbed overserved.

I submit that this method is heavy-handed and doomed to failure. Forcing a physician to go where he or she is unknown, where he or she has no family ties, where a spouse may not find employment, raises many hurdles. The prospect of professional isolation is another hurdle. When our neighbours to the south are ardently seeking young, Canadian-trained doctors, how many will agree to go north or elsewhere? And if they do and are unhappy, what kind of rapport will they have with their patients? We come back to the patient-doctor relationship, which is the key.

How should we remedy this bleak scenario? By using a carrot, not a club. The OMA has proposed an incentive program. Financial and professional advantages can work. If a doctor can improve his income and have access to consultation and further medical training, I submit that many doctors would overcome their concerns about isolated postings. After all, this happens in the armed services. Why can't we do it in the health care system?

2030

You have heard from my colleagues about the concerns regarding malpractice insurance, the CMPA, and I'm sure Dr Bos will refer to this further. This protection is important for a practising physician in case of accident or misadventure, but it is most important for patients, for if there is an unfortunate occurrence, a patient has some recourse to pecuniary recompense.

I would remind you that the reason government returns a part of the premium is in lieu of an increase in fees. The intransigent attitude of government towards payment of these funds may well have far-reaching effects on methods of practice and on adequate health care of

patients. If expert care is not available, total care will suffer and people will suffer.

I'd like to return to my theme of our concern for our patients. It has often been said that doctors don't own patients but that patients own doctors. If we get beyond billing numbers and prescriptions and medical records and offices and house calls, we, as doctors, must recognize that we are servants to our patients. We represent them. I refer to the psalmist who wrote, "He shall defend the needy among the people; he shall rescue the poor and crush the oppressor."

We live in a democratic society. I suggest our legislators remember they are the servants of the people.

In view of the fact that we've had a long day and you've had a longer one, I purposely kept my presentation short. I will now defer to my friend Dr Bos.

Dr Bos: I, like Dr Trossman, am sure that it's been a very long evening for you and perhaps even a very long week, and I very much appreciate the opportunity to address these proceedings.

I would like to speak for a moment from a personal perspective about what I think would be some of the effects on reproductive care of the implementation of Bill 26 and the termination of the CMPA rebate.

By way of background, I'm a specialist in obstetrics and gynaecology, having received a bachelor of arts in 1970, an MD degree in 1974, and was admitted as a Fellow of the Royal College of Surgeons in 1978.

I have been practising obstetrics in Peterborough for the past 17 years, and for most of these years, along with three other obstetricians similarly trained and equally experienced, each of us has cared for and delivered between 200 and 225 mothers/babies per year. We, as a group, have taken responsibility for providing consulting obstetrical services at the Peterborough Civic Hospital, where between 1,650 and 1,800 deliveries per year are performed.

We provide emergency consultation and high-risk obstetrical services for the family practitioners and citizens of this community, as well as those of Port Hope and Cobourg in the south, Lindsay in the west, Minden, Haliburton and Bancroft in the north and as far east as Havelock and Campbellford.

We work one night in four to provide these services. Each one of us works 91 24-hour time periods per year on call. To put this another way, each of us puts in 1,700 hours per year of on-call time over and above the 40- to 50-hour weeks that we work in the office or doing elective surgery in the operating rooms. This represents a huge investment in time and energy, because for us, "on call" means being available to get into the hospital and be at the bedside within 15 minutes of an urgent summons, at any time of the day or night, on any day of the year—15 minutes, whether I'm watching my kid play soccer, whether I'm eating Christmas dinner or I'm asleep at 3 o'clock in the morning—in the hospital, at the bedside.

Maybe I'm getting on, maybe I'm getting tired like Dr Redhill, but I find it more and more difficult to deal with this commitment. I really don't have a clue what kind of a problem I may be facing: a woman bleeding from a placental separation, a woman having seizures from

toxaemia of pregnancy, a woman with twins with her babies in trouble because of fetal distress. Who knows? The pressures of having to deal with sudden obstetrical emergencies and the short- and long-term consequences to mother and baby of such events can be enormous, particularly since in this increasingly litigious society the risk of being sued is almost entirely dependent on events over which we have no control. Hence the huge increase in malpractice insurance premiums.

Who gets sued? It's the obstetrician who's trying to do his level best at 3 in the morning, having been up for the preceding 36 hours looking after a myriad of other problems. With the end of the CMPA rebate program, the financial cost of practising obstetrics in this province is prohibitively high. I will have to deliver 77 babies—Dr Redhill has to deliver 90 babies; I don't know why—to cover the CMPA premiums, and of the remaining 123 deliveries that I do per year, I have to pay office overhead, taxes, RRSP contributions. A further cost, and perhaps the biggest cost to me, is the rather dubious privilege of being on call 91 days and nights per year.

Furthermore, the provisions of Bill 26 I believe are unnecessarily intrusive and restrictive to the other aspects of the practice of medicine in this province. Among other things, Bill 26 allows for a bureaucrat at OHIP, in the first instance, at least, to decide that a diagnostic test or a surgical procedure is "unnecessary" and therefore remove the costs for such service from the doctor's OHIP remittance. How can a bean counter in OHIP tell a surgeon that an appendectomy is unnecessary or an obstetrician that a Caesarean section is unnecessary? That's like a frequent flier telling an airline pilot to do a barrel roll and then billing the pilot for the cost of the crash.

Ladies and gentlemen, I despair at the consequences of Bill 26 and the CMPA rebate program to the health and welfare of my patients, because I can foresee it becoming more and more difficult, if not impossible, for me and my obstetrical colleagues, both here and throughout Ontario, to continue to provide obstetrical services—services which our communities have enjoyed for many years and indeed to which they are entitled. I'm concerned for the mother who needs an emergency Caesarean section, for the mother whose baby is in distress, for the mother who's bleeding in a life-threatening fashion. Who will care for her if there is no obstetrician?

I am profoundly disillusioned and disappointed in the Harris government's apparent inability to understand the ramifications of Bill 26 and the cancellation of the CMPA rebate program on the provision particularly of obstetrical services but also other health care services as well. These programs I believe are ill-conceived and poorly thought out. It is time for the Common Sense Revolution to inject some common sense into the relationship between doctors and the Ministry of Health. Let us stop being adversaries. Let us start working together for the benefit of all.

I'd like to give Dr Gray an opportunity now to say why he is here, because nobody knows.

Dr Gray: Actually, I'm sure to the delight of the committee, you'll be pleased to know, and I'm sure to the astonishment of many of my colleagues in the audience,

I have no formal remarks to make to the committee. However, because primarily, as all of you know, I had the good fortune to address the committee formally when you were in Toronto, I have offered to my colleagues on my left to be a resource to them, because there are some technical parts of the bill to which I'm sure some of you may wish to refer. I have had the good fortune to read the bill in detail and have been part of the process at the OMA trying to sponsor or recommend some reasonable changes. That's why I'm here.

2040

Mrs McLeod: Since early this evening I've expressed my shared concern about the effect of the withdrawal of the CMPA rebate on reproductive care obstetrics in the province, an area where I think there is a real pending crisis unless the minister acts quickly to deal with this.

I'm going to go on to another part of your brief and the concerns that you've jointly raised about the government determining what is medically necessary and the ability to deny payments to physicians if in fact care is provided that is later deemed to not have been medically or therapeutically necessary. You're quite right. As we read the bill, it would be the OHIP general manager who has the power to deny that payment and I'm sure the government members will hasten to say, "Well, he has that ability to make that decision now," although that would have to be on reference to a committee of professionals.

There is another change to this bill, one of those changes that makes us very nervous because we have no idea what it's going to mean in the future, that you can be denied a payment for a service given because it was not medically or therapeutically necessary, was not provided according to professional standards or other such circumstances as may be prescribed. And we relate that back to another section of the bill in which it says very clearly for the first time ever that the definition of "medically necessary" will not be those services that are rendered by a physician, but now will be prescribed medically necessary services rendered under such conditions and limitations as may be prescribed and those conditions would be prescribed by cabinet, by politicians. I think, even as a sitting politician, that would be equally as scary as a bean counter deciding what was medically necessary.

Obviously, this raises concerns. We have limited time. As we raised this concern earlier in the week, one of the things that one of the members of the government Ms Johns, said was that we shouldn't be worried because somehow the OMA medical tariff committee will be deciding what's medically necessary. Now, I can't find any reference to that anywhere in the act. We've raised the question with the Ministry of Health and have not yet had a response. Are you aware of any committee on the Ontario Medical Association that could be involved in this or that has been approached to be the arbitrators of what is medically necessary?

Dr Gray: I'll take a crack at that, having been a member of the central tariff committee at the OMA for four years, and the simple answer is no. That is not a body within the OMA that would attempt to undertake that kind of an exercise. The member who made refer-

ence to that may be referring to the Medical Review Committee of the College of Physicians and Surgeons. It's not uncommon at times in the past when the OMA has been confused with the College of Physicians and Surgeons, but we are separate organizations. CPSO's mandate is to protect or represent the public and the OMA's mandate is to represent the physicians of the province. So, no, it would not be the mandate of any group within the OMA and we certainly have not been approached to try to define "medical necessity."

But I think an equally important point to remember in all of this is that under schedule I of the bill, the formal agreements between the Ontario Medical Association and the government will be terminated and there will be no forum to discuss this or any other issue between the government and the OMA if those agreements are abrogated.

Mrs McLeod: The Medical Review Committee does continue to exist and, according to this legislation, would be called upon in some circumstances, but in the case of the general manager of OHIP deciding to withhold payment for a service that a physician has given to a patient, the only way you could appeal to the Medical Review Committee is for the physician to make an appeal. Whereas, as I understand it, currently if there was any question about a medically unnecessary service having been provided, that would have been a determination by the Medical Review Committee. It would be medical professionals deciding whether or not there had been, in some way, a mispractice. Is that correct?

Dr Gray: Yes.

Dr Trossman: I think that's correct, Mr Chairman. I'd like to point out, though, that we're getting off into the abstruse in discussing this. I think I would like to reassure this committee that physicians as a group, whether it is a group of two or three physicians together or a group practising in a community in a hospital or in a larger area, the College of Physicians and Surgeons, through their organization and through their peer review committee, all of which I have been involved with as chief of staff in this city and elsewhere and as a member of the peer review committee, these are all methods for, as it is called, peer review, for supervision of medical care, and indeed if a patient has a complaint, they have the ability to call the college and their complaint will be investigated.

As has been pointed out, there has been a complaint that there is a delay, but there's always a delay if there is an excessive number of complaints. However, as has been pointed out, if there is some indication that there is poor practice, shall we say, then the Medical Review Committee, which is a subcommittee of the College of Physicians and Surgeons, is empowered to look into this problem, and that is the committee that currently may refer the case to OHIP if it is found that there has been some irregular procedure.

Mr Marchese: I know that the Scott report, which had been commissioned by us, was dealing with the whole issue of distribution of doctors, and I understand the Provincial Coordinating Committee on Community and Academic Health Science Centre Relations was also studying that particular matter and many other things. I'm

not quite sure why it is that this government would not decide to consult those particular groups that are dealing with this before deciding to introduce a piece of legislation that says something totally different on their own without the benefit of this advice. Do you have a sense of what these committees are saying or proposing, or do you have a comment as to why this government might deem itself to go in a different direction without the benefit of these kinds of reports? Anyone?

Dr Trossman: Well, I can't respond for the government, but I think the general tenor of your remarks indicates a disregard for the concerns of the medical profession by the government, the abrogation of the agreements between the OMA and the government, which have existed. The minister has said the agreements of 1991 and 1993 will be terminated. If there is no forum to discuss matters of common concern, there can be no progress, and I suggest, as many previous speakers have indicated, there should be cooperation and an agreement between government and practitioners.

Mr Marchese: I've asked a few other doctors some of the same questions earlier about whether or not they think there is anything in this bill that they agree with or that they find practical, useful, effective for the purposes of enhancing our health care system. Is there anything in here that you think will benefit our health care system generally?

Dr Trossman: I know you've asked that question before, sir, and I think among doctors the immediate reaction is no. But I think on reflection one has to say that from the philosophical point of view, anything that would attempt to solve the problems that the health care system is dealing with has to be approached with an open mind. Unfortunately, I feel that the current government and Ministry of Health is not approaching it with an open mind but with an *idée fixe*, with a previously determined process.

Dr Gray: I've given some thought. I've heard you ask that question of many people, and as you asked it I've been thinking many times, is there anything in this bill that I in fact could find acceptable or even advantageous, and in fact I think there is one. At the moment, physicians in Ontario are very discouraged because we all, for the last three years under the social contract, have had earnings clawed back. But now the government is calling them contributions and I think that makes me feel good about myself—just as long as these contributions are tax deductible.

Mr Marchese: Anyway I just wanted, Dr Bos, to agree with you that I think governments need to stop being adversaries and to start working together for the benefit of all, and I think it isn't just for the medical profession but everybody who is affected by this bill. So thank you for coming.

2050

Mrs Ecker: Dr Trossman, Dr Gray and Dr Bos, thank you very much for coming and taking the time to bring forward your suggestions. While it's been a very long, tiring week, it's been also a very, very useful week, because the members of this committee do have an open mind and have been quite interested in many of the

suggestions brought forward by members of the medical profession, workers and hospital providers etc.

One of the points that you made is that we should all stop being adversaries. I guess one of the things I've had a lot of experience in various capacities with the medical profession over the years and one of the things that has distressed me greatly is that every government seems to have had some problem. The Liberals had extra-billing, the NDP had social contract, block fees and consent legislation, and it would appear that we have some difficulties over Bill 26.

One of the things I would like to assure you of, and some of this information I'm sure you already know, on the CMPA difficulty the minister has clearly made a commitment that in areas where obstetricians and GPs—we don't wish to drive them out because we need those services and they are important, and I think that's something the minister has said he wishes to address.

The points you make about the underserved area program: Again, the NDP did have the Scott report, which was an excellent report, and one of the things Mr Wilson has tried to do is to start moving on some of those suggestions—financial incentives, the beginning being the \$70 emergency fee, but also the training of young doctors, CME support, locum support, those kinds of issues—because we recognize that it has to be a multifaceted approach in order to get physicians within the area.

One of the areas that you've talked about is the difficulty with deciding medically necessary, whether the general manager—as you know, the general manager now, with the powers under the Health Insurance Act and OHIP, makes the decisions of what is medically necessary for payments based on physician advice, and I think that is certainly something we want to ensure and continue in the process.

The Medical Review Committee—which again, as you know, is not patient-driven, not patient complaints that make that, it's the information from OHIP, the general manager, that drives the Medical Review Committee—the college has said there are problems with it; it's not working as effectively as it can be. If we were to have proposals to streamline the Medical Review Committee to make it more effective, to make it do what I think most physicians agree is something that has to be done, would we be able to solve the difficulties of medically necessary, who determines that? Would we be able to solve the concerns about confidentiality, because if it is under the auspices of the CPSO with physicians and the public members on that committee, who are under confidentiality restrictions etc? Would it address those two issues which you have pointed out, any of you?

Dr Trossman: I would think the answer to that is yes. Although it may be peripheral, I have referred to the peer review committee, which is not quite the same thing.

Mrs Ecker: That's true, yes.

Dr Trossman: I refer to it because I've had experience with it. For example, when it started some 15 years ago, the pattern was to have two assessors review a physician and it has been found that it is adequate to have one trained assessor do it. The same thing could be done with the MRC, and I'm sure that if the appropriate approach was made to the college, which supervises, that could be effected.

Mrs Ecker: Okay. Just to change topics a little bit, one of the things that we've heard mentioned here at the hearings is difficulties with the prescribing of drugs, to seniors particularly, but other people, and obviously the inappropriate prescribings, a minority of physicians. But we've also heard many physicians talk about the need for clinical guidelines for prescribing, for practice etc. Some physicians have said to me that they're looking for more guidelines on that.

Do you have any guidelines on how the ministry can encourage not only the development of appropriate clinical guidelines for practice and for prescribing, but also ensure and help to make sure they are followed? Because that's always the debate. You can get guidelines, but how do you ensure that practitioners are educated about them and then are prepared to follow them? Have you got any comments on how, as a government, we can assist that process?

Dr Bos: I'd certainly agree that there is the need for some kind of ongoing, some kind of continuing medical education in the very rapidly changing fields in which we practise. I think there's a danger in having clinical practice guidelines in terms of getting involved in cookbook medicine. Medicine is not a Betty Crocker recipe. It is a combination of training, of science and, probably most importantly, of art, of having the nose to smell a rat, of having that *je ne sais quoi* that you can't teach anybody but which you gain by dint of experience of being up at 3 o'clock in the morning and seeing it all.

I would agree that on the one hand there needs to be a mechanism in place to help physicians to keep themselves up to date. How the ministry can help in particular I really don't know. That's certainly a question that is worth addressing seriously.

The Chair: Thank you. We appreciate your presentation and thank you for your interest in our process.

Before we leave, I want to thank the people of Peterborough for allowing us to have a good dialogue with the presenters and we appreciate your cooperation. We are adjourned till Monday in Windsor.

The committee adjourned at 2057.

Continued from overleaf

Peterborough City Radiologists	G-872
David Swales, representative	
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Robert Patrick, representative	
Peterborough County Medical Society	G-879
Dr Marshall Trossman, president	
Dr Carlos Bos, representative	
Dr John Gray, past president; chair, OMA board of directors	

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

*Marchese, Rosario (Fort York ND)

*Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Johns, Helen (Huron PC) for Mr Danford

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Also taking part / Autre participants et participantes:

Curling, Alvin (Scarborough North / -Nord L)

Galt, Doug (Northumberland PC)

Gerretsen, John (Kingston and The Islands / Kingston et Les Îles L)

McLeod, Lyn (Fort William L)

Miclash, Frank (Kenora L)

Rollins, E.J. Douglas (Quinte PC)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Campbell, Elaine, research officer, Legislative Research Service

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Legislative Assembly of Ontario

First Session, 36th Parliament

Assemblée législative de l'Ontario

Première session, 36^e législature

Official Report of Debates (Hansard)

Monday 15 January 1996



Journal des débats (Hansard)

Lundi 15 janvier 1996

Standing committee on general government

Savings and Restructuring Act, 1995

Health issues

Comité permanent des affaires gouvernementales

Loi de 1995 sur les économies
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Monday 15 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Lundi 15 janvier 1996

The committee met at 0859 in the Ramada Inn, Windsor.

SAVINGS AND RESTRUCTURING ACT, 1995
LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Good morning, everyone. It's nice to be in Windsor. You probably won't believe this, but I used to live in this city a few years ago.

Interruption.

The Chair: Anyway, we are happy to be here. We're here to listen to the concerns of the people of the city of Windsor. We have several groups going to present to us today and hopefully they'll get an opportunity to do that.

Oh, I'm sorry, Ms Lankin.

Ms Frances Lankin (Beaches-Woodbine): Thank you, Mr Chair. I just wanted to make note of the fact that I have filed with the clerk two motions: one dealing with the committee coming back to Windsor to hear from those people who've not been heard from, and another dealing with a demand that the government file the amendments to this bill. Those motions have been duly filed with the clerk and I'd be prepared to move them at a time where you schedule them for debate.

The Chair: As probably has been our custom, out of respect for our presenters, we'll deal with those at our lunch break, if that's satisfactory.

SANDWICH COMMUNITY HEALTH CENTRE INC

The Chair: The first presenter this morning represents the Sandwich Community Health Centre: Isabella Cimolino, who's the executive director. Isabella, you have a half-hour of our time. Questions, should you leave time for them, would begin with the Liberals and would rotate around the table.

Mrs Isabella Cimolino: Thank you and good morning. The thrust of this presentation and its primary focus is on process, process as it relates to the Sandwich Community Health Centre and consequently the impact of Bill 26 on these processes. It will be brief in deference to those who are following me, and I will even read the presentation as

opposed to ad libbing because when I ad lib, I tend to go over time.

To this end, attached to the presentation is the mission statement of the Sandwich Community Health Centre and the latest copy of its newsletter, Health Smart. From that mission statement you'll find that we're a community-directed organization that works with its community in the achievement of optimum health, looking at physical wellbeing as well as others, and we do so from a primary care perspective, as well as focusing on health promotion and diseases prevention. So with that in mind, I will now go through the presentation itself.

Since its official opening in November 1989, the centre board and staff have worked with the community to determine its health status as well as ways in which this could be improved, including how, working collaboratively, we can make Sandwich a better place to live.

Focus groups, town hall meeting, needs surveys which involved completion of questionnaires door to door, for example, are a number of the ways in which we obtained public input upon which to develop strategic plans and operational plans which assisted us in making the decisions necessary for the deployment of resources, both human and financial.

We have paraphrased an old Chinese proverb which says, "Tell me and I will forget; show me and I will remember; involve me and I will understand." I think that latter part, the involvement and the understanding, are what is critical to today's times. We're long past the time where somebody knows better and imposes upon the people whatever they think happens to be best for others.

It's not necessarily the easiest way to proceed, but in the long run it's the most gratifying. When we do put together a program, it's one that's attended because the people we're serving have helped us develop it. They then have ownership in it, and that means they then go out and bring in the parties who can best benefit from whatever we have developed.

In bringing common sense to health care in December 1994, the Progressive Conservative Party stated, "The public should be a key player in determining local community health care priorities." It's suggested that the provisions of Bill 26 totally contradict this particular statement.

Our clients are served by a team of health care professionals which includes physicians, nurses, social workers, a chiroprapist, a dietitian and health promotion specialists. The administrative support to this is two people, an administrative assistant and myself, so we can't say we're heavy in administrative costs. Clients provide explicit consent to the Sandwich Community Health Centre, both when they first become our clients

and then through different processes, as we deal with external organizations, they become even more specific to ensure that the client has some sort of control and some sort of knowledge and some sort of input into what is about to happen to them.

The implied consent that permeates Bill 26 which allows the minister or designate to access client records is of great concern to the centre. It detracts from the notion of assuming greater control over self and thus has the potential to nullify clients' participation with respect to decisions regarding their health, not to mention, I suggest, a breach of current standards of confidentiality.

On a microscale, the services in a community health centre are integrated. This integration of services must occur at a macroscale to ensure the development of a system of health and health care in order that we better serve clients' needs efficiently, appropriately and cost-effectively. The centralization of authority in Toronto will jeopardize this integration, will deny communities the opportunity to set their own health and health care priorities and thus design a system which will address these priorities.

Another one is, as we look at the section that deals with independent health care facilities, that a community health centre is currently incorporated under the Ontario Business Corporations Act and we're governed by a volunteer board of directors. Much of our work is done in committees, with our directors, residents, clients and staff working together for the betterment of the community as it relates to health. The provisions of Bill 26 as they relate to independent health facilities have the potential, we suggest, to render this volunteerism obsolete because there exists the possibility we could be declared an independent health care facility. This is of concern to us.

There are other provisions of this bill upon which we could comment, but I think the previous examples give you an idea of the concerns we have. There are others here today who will speak to the other areas that are of concern to us, which are the Ontario drug benefit plan and things that the physicians will be addressing, things specifically from their perspective.

No matter how I read that bill and no matter how I would put the "mays" rather than the "shalls" and all the rest of it, to all intents and purposes it has every appearance of being a power grab of leviathan proportions and it is moot as to whether the end actually justifies the means. I think we have to look very closely at that.

We do have some recommendations, and probably I could have gone an awful lot further with these, but again, I defer to time and perhaps the opportunity to answer questions from the members of this committee. But we will certainly send the message that we have to resist the temptation to centralize authority in Toronto. It's not just the centralization of authority; it's the kind of authority that's being centralized.

I would hate to think that one person sitting down there can make a decision as to the health care that I'm receiving from my family practice physician or whoever else I happen to be getting that from. They don't know me, they don't know anything about me, they don't know anything about my health, so why should this person be making a decision? I will rely on making the decision

with the input from my practitioner, whoever that may be, and on that basis I think my health will be better served.

So we have to look at the centralization in Toronto. Toronto doesn't always know what's best for the rest of Ontario. They might think they do, but we know you really don't. We are quite diverse, we really are. There's no place to allow communities to plan their own local health system. We have to allow communities, in conjunction with medical societies and the Ontario Medical Association, to determine the requirement for physicians of all stripes so that there will be family practice physicians, specialists and what have you.

Here I emphasize the local end of it because it has to be done on a health status basis. We have to look at the health of the communities being served and make a determination from that. If, say, in Windsor we need more orthopaedic surgeons than some other area might need, so be it. But it's only the local communities that can make that determination, working with their physicians and coming up with a plan so that then, when people go into medical school—this is only a suggestion, by the way; the Sandwich Community Health Centre's thinking certainly isn't anybody else's necessarily—they know what's needed and they know where the jobs are. It's a better way of controlling it than suddenly pulling the rug from under somebody's feet and saying, "You don't have a billing number any more." I would suggest that is not a terribly appropriate way to proceed.

0910

If any of you were watching Canada AM this morning, there is a report that has not been released yet—this is a pre-release—that has to do with the migration of Canadian physicians to the US, but part of it also deals with the suggestions and recommendations from a diverse group as to the practice of physicians in Ontario. It struck me, as I look at this planning thing particularly, that for every two physicians who go to the States, one comes back. But it was a comment I heard made, "Well, Canada has too many physicians anyway." Now, you wouldn't know that from necessarily Essex county, and I may add Kent county, because we certainly do not have an overabundance of physicians and our physicians consequently work extremely hard.

The point was, I thought it was such a comment that just emphasizes the fact that we have to plan, and planning needs diligence in conjunction with the service. But move the decisions closer to where the services are delivered, to the front-line workers, and that of course includes physicians, includes nurses and includes all of these people who directly serve Ontarians.

We ask that you support the integration of services at the local level. If all health care providers work together cooperatively, the efficiencies will occur. They can't help but occur if they're working closer together.

You must respect their clients' confidentiality; and although I say that, I now move into another section where somehow or other we move to the technology to develop a smart card that will protect this confidentiality.

If in Scotland I can access my bank here in Windsor or in Chatham, Ontario, surely we can come up with something that would protect the confidentiality of the

client. But, because of the client tracking system inherent in that process, then we can better serve our clients, and if there's any misuse of the system it will be identified, whether that misuse is by the person receiving the services or the person providing the services.

To suddenly go out and start trying to find abuses of the system—I worked in government service for an awfully long time, both in Britain and here, in the sense that I've usually worked in the public, if not directly as a civil servant, and usually these abuses are greatly magnified as opposed to the reality. The things that are set up to stop them are usually worse than what they're trying to stop.

I think also that it better serves, and more importantly, clients in that they won't receive inappropriate medication. I hear our physicians speak sometimes as I'm walking by. They go to a walk-in clinic, they get a prescription that's not an appropriate prescription and then have to try and undo what has happened in that particular environment; or a walk-in clinic has sent somebody to a specialist without consulting with their family practice physician and a letter comes back to the family practice physician saying: "We don't know why this person was here. She should never have been there in the first place." So I'm suggesting there are other ways of doing things, and perhaps we should be looking at the smart card, rather than scrapping it, as a possibility.

I would certainly suggest that the Progressive Conservative Party adhere to the processes, values and beliefs, with respect to process, as you set out in the Common Sense Revolution and your health care bill of rights, one of these rights being that Ontarians have the right "to participate in decision-making regarding one's own health and the right to treatment free of discrimination and which recognizes one's privacy, dignity and individuality." With all due respect, Bill 26 is a total contravention.

These are your words that I have read from the various documents coming from the PC government when it assumed power. I took it upon myself to read all these things to have an idea of what would be happening to us.

As I said, there are other things I could focus on, but I'll let others do that, and I'm sure they will. But there is one thing I was thinking of this morning which I should have put in there. Canada has a unity problem sometimes, but one thing that struck me was that when they took a poll of Canadians coast to coast, regardless of province or where people lived, 82% to 84% supported our medicare system. That is a very high percentage.

There's already private coverage to the extent of somewhere around 22%. I was just thinking this morning, how far do we want that to go? With all due respect, I suggest that the percentage of privatization, if it has to occur at all, has to be limited and it certainly has to never exceed the public part of it. I believe health is a right, and health care is an extremely important part of health, and probably most of the people across this province and across this country would agree with that. The poll certainly suggests that. I throw that in although it's not in the brief, because it is of concern to me.

All that's left for me to do is thank you for the opportunity to make this presentation, but I would be remiss in not saying a special thank you to the loyal

opposition and the New Democratic Party, who have made these hearings possible.

Mrs Sandra Papatello (Windsor-Sandwich): For the information of committee members, Sandwich Community Health Centre is one of the examples that would be continuing should the Win/Win proposal ever come into place in this area, specific to our health services in Windsor-Essex county where savings in health and hospitals was to be redirected into community health services. Your organization is one of those examples. What does this bill do in addition to the fact that the Minister of Health has not continued to be committed to the win-win proposal for Windsor? How do you see this being affected, compounding the problem especially where your clientele are concerned?

Mrs Cimolino: With respect to our clientele, I don't have a crystal ball to see where the directions are going, but I've certainly indicated the processes involved in the community health centre. That could go by the board. My experience has been, as I look over the past eight years—we opened officially in 1989—to see the differences in the community and work with them. We do access federal dollars, working with the community to address things like environmental needs and also our healthy mothers/healthy babies program. There's going to be an announcement on Wednesday from Mr Rae with respect to federal input into that process.

Depending on the road taken, it could be adversely affected, but we could also possibly benefit. Because we are an integrated service, we're all paid by salary; that includes physicians. I'm usually a perennial optimist, but this line from the poetry of Robert Burns keeps coming through my mind, "An' forward, tho' I canna see, I guess an' fear!" That is from the poem To a Mouse. It keeps coming up. It could be negative, but I see it also as a positive. I'll certainly, as an individual, do everything I can on behalf of the clients we serve to ensure that whatever adverse effects occur are as minimal as possible, working with the community.

Mr Bruce Crozier (Essex South): Thank you for your presentation. Notwithstanding the fact that the Conservatives gave their solemn oath not to cut any funding from health care, we see now that about \$1.3 million, earmarked to reduce the deficit, is going to come from health care, without any plan that we can see. When we have downsizing in medical services, in hospitals, where do you see community health centres in this situation at the present time, when funding is definitely going to be reduced for health care yet there's no plan out there for how that is going to be shifted to community health centres and how they're going to be funded?

0920

Mrs Cimolino: With respect to our community health centres, we've already seen the impact of early exits from hospitals and that type of thing. You don't have home care. The family practice physician is still in charge of that, so consequently, as it moves into the community, even if it might be VON or somebody of that ilk providing the service, the impact is great on our physicians to deal and to give the direction.

That's only the start, and I think it will get worse if there are no resources allocated to the community sector

to do that. That's probably what Sandra was thinking of in terms of the promise that if we had any savings from the hospital sector, it would be reinvested into the community, one which is now in jeopardy and it will all go into the same pot. In fact, we will have a plan in Essex county. I don't want to steal the thunder of the district health council, which is coming later this afternoon; they will be able to address that much better than I. But we are already feeling the impact, and we're trying to do the same.

Now, we still have a similar amount of dollars—we've been most fortunate—and I think that is a recognition of the work we do. But the impact on services is great, and we are looking very strenuously at the moment how to reorganize internally to address the much greater demand on our services.

Ms Lankin: Thank you, Isabel. It's a pleasure to see you again. I highly recommend to the government members of the committee, if they get a chance to come back to Windsor, to visit your community health centre. It's an incredible operation, located in a school, well integrated into the community. I remember well the opportunity I had to tour it. The work you do is very important and serving an important constituency in the Windsor-Sandwich area.

I want to also address the issue of community participation and community control and community planning for our health services. Here in Windsor you went through a process to come together to determine the direction of not just hospital services but health care system restructuring, which I think is important.

This bill sets out a new process: a minister who can make a decision any time he wants about hospital closings; a hospital restructuring commission that has no terms of reference, no controls on its powers, that can implement anything it wants; and nothing in the legislation that relates it back to the work of local planning processes and reports, such as the one here that was led by the district health council.

The government gives us all sorts of assurances that that's what it intends, but this is the same government that has withdrawn the commitment that was made to Windsor to reinvest the dollars from the hospital savings into the community to ensure that there is a seamless system.

We're interested in seeing the government amend that section of the bill to give a very clear linkage that what the minister and the hospital restructuring commission are going to do is based on, has some relevance to, the local community planning process that communities themselves undertake and the decisions they make for themselves. Would you be supportive of that kind of amendment and could you speak about what that might mean in terms of this community and resources into community services?

Mrs Cimolino: I would be 100% supportive of that position. I've been involved in the process you've just described since 1991, first of all as a citizen and then as part of the district health council. I'm now chair of the community restructuring segment of that process, and exciting things are emerging from that community process. Again, I don't want to speak too much, because

the district health council will be making a presentation in that regard.

But we have a planning vehicle, and they're called district health councils. The money is already going into district health councils and they are working with their community. The format could change; I'm not saying that. But use the vehicles that are already there. Communities are at different stages in this. I think we're a wee bit ahead of some of them, because we were invited to speak to the Metro Toronto District Health Council. Anything that keeps the planning, the decision-making at the local level where they have a firsthand knowledge of the needs of the community, looking at it from a needs perspective, ie, health status and all these things, yes, it's the only way to go.

If we have, as this person said, and I've heard it before, too many doctors in Canada, obviously we haven't planned well, and it's hardly fair to the people entering medical school, the profession. It's already happened to teachers and to so many other places, that the jobs just aren't there. That's a rather difficult situation. Are we as Canadians going to train doctors so they can go to the States? I don't think that's terribly acceptable and I don't think half the physicians would find it terribly acceptable either.

Ms Lankin: The other area you raised in your presentation was concerns about the Independent Health Facilities Act. I'm sure you know that the current legislation has in it a provision that gives a preference for Canadian-owned, not-for-profit delivery of services. The government is taking that provision out. I can't read anything into that but to open up the door to competition from for-profit, foreign-owned. Otherwise, why would you remove that provision? In fact, government members across the way said in other communities last week: "So what's wrong if someone wants to come from Korea or the United States or wherever and run it and make a bit of profit? If they're doing it more efficiently, then great."

I have grave concerns about services to people being turned over to the for-profit sector and I have grave concerns about what that means in terms of our medicare system and the values in our communities that are exemplified through our commitment to medicare. Can you comment on that from a Windsor perspective? You're very close to the American system across the border.

Mrs Cimolino: This is the town that was first in so many things. We had the Windsor medical association. The unions in this area have very much been advocates of the non-profit delivery of medical services. As I stated earlier, we have to look very closely at that and we must not, cannot allow ourselves to be taken over by the for-profit and end up like our friends across the border, where it's said that 52 million people do not have any medical coverage and a great many more don't have satisfactory coverage, and this is in a country where they spend more money on health per capita than any other country in the world. Do we want that? I would suggest not, and certainly they're not the values and beliefs I hold as an individual, albeit a naturalized Canadian citizen, but I'm in Canada because Canadians think similarly to me, although not quite the same, because I come from a British tradition.

Mr Tony Clement (Brampton South): Thank you for your presentation. It was very thoughtful and certainly has given us some things to think about.

I just wanted to talk about a couple of areas of your presentation. First of all, as Ms Lankin has already raised, you feel very strongly about the need not to centralize the authority in Toronto, and I couldn't agree with you more on that. I've been drawing to the attention of some of the presenters who've raised that issue before the fact that in Bill 26 there's no mention of district health councils, which some people view with alarm, but what that means is that the provisions currently in the legislation on district health councils still apply, so district health councils are still there to advise, to plan and to make recommendations.

If we made that more explicit, if we drew the connection between district health councils and the hospital restructuring, do you think that would satisfy some of your concerns?

Mrs Cimolino: If you did make things more explicit, certainly we could understand and it would not be subject to the broad interpretation it currently has. But any legislation that denies the right of appeal to whomever—my background is that I have a law degree. I find that so offensive because now I'm subjected to the interpretation of one person or maybe even two, without any recourse to anybody.

What one intends and how it's interpreted are so different. I sat through the Municipal Act that was just written, and it was pulled apart by law students with the writers, and all they could say was, "But that's not the intent." That is the English language. This is an interpretation this language could stand. You must have appeal or some way of getting interpretation of that, and the more explicit you can be, the better.

Mr Clement: Can I talk a bit about the disclosure of medical records? You raised the issue of your concern over deeming to disclose automatically. Under the current legislation, you are deemed to disclose as well, and in fact the new legislation under Bill 26 restricts the conditions under which you're deemed to disclose. But I acknowledge that perhaps must be a bit more calibrated, made a bit more specific, maybe made more anonymous. I want your comment on that.

0930

You've mentioned the smart card. The Minister of Health and the Conservative caucus very much believe in a smart card as well and we would like to implement that technology. But you've got to do a bit of a balance between the smart card and the technology and how that intersects with keeping medical records confidential. Could you comment on those two aspects of your proposal?

Mrs Cimolino: I agree totally there has to be in this technology some ways of putting checks and balances. I don't understand why we can put a man on the moon, a man someplace else, and yet we can't do something like that. There has to be a way of doing it. We are in the technocratic age. We are going to be exposed more and more to these things. It behooves us very early in the process to develop these opportunities for confidentiality because we are going to have to live with it for an awful long time.

Mr Clement: So you see no contradiction—

The Chair: Thank you very much, Mr Clement.

Thank you. We appreciate your interest and your presentation this morning. Have a good day.

Mrs Elinor Caplan (Oriole): Mr Chairman, can we get a few more chairs for accommodation? People are standing and waiting in the hall and I think there is room in the room for some more chairs, if that would be possible. Could you see if that could be arranged?

SERVICE EMPLOYEES UNION, LOCAL 210

The Chair: Our next presenter represents the Service Employees Union, Local 210, Mr Ken Brown, the president. Good morning, Mr Brown. Welcome.

Mr Ken Brown: Thank you and thanks to my few friends I brought along with me this morning. On behalf of the 4,000 members of Service Employees Union, Local 210, employed in health care facilities in Essex-Kent, Lambton, Huron and Bruce counties, we welcome this opportunity to express our views on Bill 26 as it impacts on health care.

At the same time we must state our objection to the obvious intent of this government, which is to pass the legislation by the end of January with little or no regard to the input to be received at these hearings. The whole process, frankly, seems undemocratic.

With the introduction of this bill the government is proposing sweeping and fundamental changes without adequate public debate. It has become apparent in recent weeks that no one, including members of the government itself, has had adequate opportunity to study the bill and how its passage will affect our society.

The Premier talks to us about the need for less government, and yet the unifying theme of Bill 26 is to gather greater unprecedented powers into the hands of government ministries and the Ontario cabinet. In the words of Thomas Walkom in a December 2, 1995, article in the Toronto Star with respect to this legislation and its process: "In the world of rational order, there is no room for dissent and precious little role for the elected representatives of the people. The government marches on...."

As it relates to health care, the omnibus bill creates a new health act and a Physician Services Delivery Management Act and amends the following: Ministry of Health Act, Public Hospitals Act, Independent Health Facilities Act, Ontario Drug Benefit Act, Prescription Drug Cost Regulation Act, Regulated Health Professions Act, 1991, Health Insurance Act, Health Care Accessibility Act, Pay Equity Act, Hospital Labour Disputes Arbitration Act and other interest arbitration legislation.

Some of the substantial changes in the bill include:

A rollback on pay equity for women.

The deregulation of drug prices and the introduction of user fees for the Ontario drug benefit plan.

The increased power of cabinet and Minister of Health over hospitals and doctors. Under this bill the Minister of Health would be able to close hospitals, appoint a supervisor to take over hospitals or tell individual hospitals what services they can or cannot provide.

The repeal of existing laws giving preference to Canadian-owned, non-profit health care providers and the

removal of a public tendering process. It would appear that the door is open to American for-profit companies to set up clinics in Ontario.

The opening of the door to new user fees for a wide range of health care services including hospital services.

New rules for bargaining with hospital workers, forcing arbitrators to consider the ability to pay and to further consider the possibility of service cuts in deciding wage levels.

Sweeping immunity of government at all levels from the legal challenge.

The absence of an appeal process for health care providers or citizens.

It is our belief that no sector will be as significantly affected by Bill 26 as will be health care sector. It will surely impact the quality of care in a negative way. It will profoundly damage publicly funded medicare and encourage the privatization of health care. It is an attack on the elderly, the poor and all of those in society most in need of quality care. It permits and even encourages extra billing and violates the Canada Health Act.

If this legislation is enacted, we will see a rapid encroachment by the private sector looking to make profit on illness and disability. We need only look to the US to see a shining example of that type of health care system, where an estimated 44 million people have no health care coverage and another one third of the population is underinsured.

The United States is the richest country in the world. They spend more money per capita on health care than we do, but in the end only provide quality care to the rich, create huge profits for insurance companies and health maintenance organizations and leave an estimated 60% of their population either uninsured or underinsured. We do not believe that most Ontarians want this kind of health care system.

Schedule F of the legislation, health services restructuring, provides the government with arbitrary power to close public hospitals and to invite private profit-making corporations to open licensed fee-charging facilities in Ontario. It allows for the introduction of user fees and extra billing practices and, in our view, firmly establishes two-tiered medicine. The changes to be implemented under this schedule are an attack on the principles of the Canada Health Act.

Schedule F amends the Public Hospitals Act, the Private Hospitals Act, the Ministry of Health Act and the Independent Health Facilities Act.

The Public Hospitals Act: Significant components:

Bill 26 will give the minister virtually unlimited power to dictate every detail of the hospitals, including the funding, operation, closure and amalgamation of hospitals.

It fundamentally changes the democratic community governance structure of community boards of directors of hospitals. The minister has the power to override decisions of the community boards of directors without their input.

It ensures that fiscal and budgetary responses alone can close or amalgamate hospitals without regard to the impact on quality of care.

It can direct hospital supervisors to implement the minister's decisions and to take over the powers of the local board of directors.

Bill 26 protects the minister, investigator, hospital supervisor and board of directors from any liability as a result of hospital restructuring.

Funding: Under the old Public Hospitals Act, sections 5 and 6 gave the minister the power to give provincial aid to the public hospitals as defined by regulation. In Bill 26 these sections have been repealed and replaced with clauses giving the minister discretion over when, how much and under what conditions the minister will give grants, loans and/or financial assistance. He also has the power to require repayment and to reduce or terminate grants and loans. His only criterion is that he must consider the public interest.

The new section 6 gives the minister the power to close hospitals, order hospital amalgamation and specify the services to be delivered by a hospital if the minister deems it in the public interest. The effect of these provisions is to give the minister significant discretion to decide all hospital funding matters without regard to any of the objective or limiting criteria contained in the present regulations.

Public interest: "Public interest" is used throughout schedule F. The definition of "public interest" is added to the Public Hospitals Act in section 9.1. The clause states that the minister and cabinet are not limited by these matters and can consider "any matter they regard as relevant."

The list includes the quality of management and administration of hospitals; the quality of care and treatment of patients in the hospitals; the proper management of the health care system in general; and the availability of financial resources for the management of the health care system and for the delivery of the health care system.

The availability of resources is entirely a matter of priority. The Minister of Health may well find less resources available for health care because more is needed to cut the income taxes of the well-to-do.

Section 9.1 and amended section 13 also protect the minister and cabinet from any legal liability from any decisions as a result of their direction or level of funding.

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Ministerial power to close, merge or make other directions: Bill 26 fundamentally alters the relationship between public hospitals and the government. It replaces the overdependence of hospitals and the communities with the overriding control of the Minister of Health and cabinet.

The courts have ruled that, under the existing Public Hospitals Act, the minister cannot act for fiscal or budgetary reasons alone or without regard to the effect on patient care in deciding to close or amalgamate public hospitals. However, under Bill 26 the minister is empowered to order the closure and amalgamation of public hospitals whenever the minister considers it is in the public interest. The bill also provides that no amalgamation can take place without ministerial approval. In making decisions, the Minister of Health is authorized to take into account any matter he or she regards as relevant, including the availability of financial resources.

Under the bill the minister is also given power to direct a hospital to provide specified services and dictate the extent of the services. The minister also has the power to make any other direction related to the hospital that the minister deems in the public interest. In effect, this section of the act grants the minister the power to virtually dictate any aspect of the operation of public hospitals.

When ministerial directions are given, the bill provides that the board of a hospital must carry out the direction. Throughout all of this, the minister and cabinet are insulated from any legal liability with respect to any direction given to the hospital or the effect of any funding decision.

Powers of investigation and supervision: The power of cabinet to appoint investigators under the Public Hospitals Act has been expanded under the bill to allow investigators to investigate any matter related to the hospital, again where cabinet considers it advisable in the public interest to do so.

Under the existing Public Hospitals Act, an investigator could be appointed "to investigate and report on the quality of the management and administration of a hospital" and "the quality of the care and treatment of patients in a hospital." New section 8.1 adds "or any other matter relating to a hospital where the Lieutenant Governor in Council considers it in the public interest to do so."

In addition, Bill 26 authorizes cabinet to appoint a hospital supervisor whenever cabinet considers the appointment to be in the public interest. In the former Public Hospitals Act there was a requirement that an investigator's report first be completed and considered for a 30-day period.

In Bill 26 the powers of the supervisor are expanded. Instead of providing advice or direction to the hospital board, the supervisor now has the exclusive right to exercise all of the powers of the hospital board. The supervisor can now completely take over the board of directors or the corporation managing the hospital. Previously, under the existing Public Hospitals Act, the board or corporation had the obligation to follow the supervisor's advice. Now, if the boards resist ministerial direction, they can essentially be removed from office.

Also previously, the supervisor was required under the Public Hospitals Act to report from time to time to the minister. Now he is required to follow directions issued by the minister with respect to the supervisor's powers which themselves are virtually unlimited.

Again, the bill protects investigators and hospital supervisors from liability for any action or omission.

Physician appointments and privileges: Section 32 of the bill gives the minister the power, with the approval of cabinet, to make regulations including the appointment of physicians and the requirement for each hospital to submit a "physician human resource plan." These provisions, taken together, give the minister and cabinet potentially unlimited control over fundamental decisions relating to the appointment of physicians in public hospitals and, accordingly, over the ability of physicians to work in public hospitals and of their patients to have access to their services while in a hospital.

In addition, the bill provides that cabinet, by regulation, could prevent physicians from using the courts for damages for refusal, alteration or termination of their appointments or privileges even if the hospital is not closing. Physicians also do not have any right to appeal.

It also gives the power to the minister to make regulations concerning hospital subsidiaries, hospital foundations and the disposition and/or purchase of hospital assets. Large amounts of dollars are sitting in these funds and no one knows what will happen to them when hospitals close or merge.

Once again, the bill extends to hospitals immunity from any liability.

Private Hospitals Act: The significant components:

The minister has the power to close or terminate any grant of any private hospitals without notice.

Hearings or rights of appeals have been repealed.

The minister is protected against liability.

In schedule F the minister amends the Private Hospitals Act to give the minister the power to revoke a private hospital licence at any time, and to reduce or terminate any grant, loan or other financial assistance, without notice, where the minister considers it in the public interest.

No hearings or rights of appeal presently provided under the Private Hospitals Act would apply. Again the minister is immunized from any legal liability as a result of closure or a funding decision.

The Ministry of Health Act, significant components:

Bill 26 establishes the Hospital Services Restructuring Commission whose mandate is to implement the government's agenda on hospital restructuring.

The commission is totally protected from any liability in implementing hospital restructuring.

Section 8 of the Ministry of Health Act deletes any references to district health councils.

Bill 26 repeals section 8 of the Ministry of Health Act.

The old section 8 established the Ontario Council of Health, which is a senior advisory body to the minister on health matters. It also established the district health councils and outlined their functions. Finally, it provided direction to DHCs in respect to first nation or aboriginal communities.

The new section 8 does not mention district health councils. The removal of the references in section 8 of the district health councils makes it very unclear as to the government's intention for the DHCs and the relationship between them and the Health Services Restructuring Commission.

I heard a comment to the last speaker on that point. Although we've had our difficulties with the DHC and the reconfiguration process in Essex county, clearly without that kind of body to do what we've done in local planning, we certainly would not have accomplished what we have managed to accomplish with regard to the health care restructuring, the amalgamation of four hospitals into two in this community in the last four years.

Section 8 is replaced with a section that creates the Health Services Restructuring Commission. This group will be appointed by the Lieutenant Governor in Council and can be assigned duties by regulation under terms and conditions determined by cabinet. There are no restric-

tions on the duties of this commission. The minister could delegate this authority to the council, who will be empowered to carry out restructuring in whatever way he deems appropriate.

The Independent Health Facilities Act, the significant components:

Bill 26 expands the definition of independent health facilities to include any facility or service that the minister defines through regulation.

It allows for the expansion of independent facilities licensed to charge a facility fee over and above what they receive from the government for insurance services. This is called extra-billing.

It repeals all preference to non-profit or Canadian operators, thus opening the door to private American or profit-making corporations to open licensed, fee-charging facilities in Ontario.

It removes the requirement for public tenders and allows the minister to send a request for a proposal to one or more specified persons.

Under the existing Independent Health Facilities Act, services covered by the act can only be provided in licensed health facilities. Generally speaking, these services presently covered by the act include various diagnostic, surgical and other services provided in outpatient clinics, for which facility fees are paid by the Ministry of Health.

Bill 26 proposes changes to sections of this act which challenge our ability to maintain a universal, accessible, not-for-profit, publicly administered health care system in Ontario.

In Bill 26, the terms "facility fees" and "independent health facility" are redefined to allow for a charge or fee to be made for any service designed by the minister and includes any facility the minister defines through regulations.

Independent health facilities can be expanded far beyond their present use in the system and will be permitted to charge fees to insured persons. This also is extra-billing.

The definitions for "health care" and "health record" are repealed, and in subsections 3(2) and (3) "insured service" is changed to just "service." This allows for deinsuring services and implementing user fees in other parts of Bill 26.

The Americanization of our health care system: The bill repeals the language that directs the minister in the Independent Health Facilities Act to give preference to non-profit Canadian operators and to solicit proposals for new facilities from the general public.

Under Bill 26, this requirement would be repealed. Instead, the minister can direct that a request for proposals be limited to one or more specified persons. This raises the real possibility that for-profit US health care providers will be licensed to provide health services in Ontario. American corporations are extremely interested in our health care system. They call it the "unopened oyster" and care for the elderly is referred to as "mining grey gold."

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Under the act, there is no obligation to notify those who submit unsuccessful proposals or to give reasons for

the decisions. There is no right to a hearing or appeal. In addition, there is no appeal process if the minister refuses to designate a health facility, if the director refuses an application for relocation or if the minister revokes licences or eliminates services. While there is no right to appeal, the minister and the director are protected from liability for licence decisions.

These changes allow the Minister of Health to hand-pick corporations or individuals who will be able to open up businesses and franchises of health care clinics that charge people money. In tandem with the massive cuts to hospital services, it seems that the new legislation will allow health care gaps to be filled by more private clinics or organizations intent on making profits from the sick and the elderly.

If you've got my presentation and you're following along, pass over the next section and go down to the bottom of that same page, to "Limitations on Physician Affiliation." The bill also empowers cabinet to make regulations governing the terms and conditions of affiliations between physicians and independent health facilities so that physicians can only operate out of or work in licensed facilities in accordance with whatever requirements are established by cabinet.

Power to set fees and amounts payable: The bill empowers cabinet to unilaterally determine, by regulation, the fees and other amounts payable in relation to the operation of an independent health facility under the act. Cabinet also has the power to set the amount of fees at zero. As well, the minister has the power to set off or deduct against future payments amounts that in the minister's opinion should not have been paid for any reason prescribed in the regulations, with no right of appeal provided. This means that if a doctor provides a service that later the government decides was unnecessary, the doctor will not get paid for providing that service. This process could lead doctors to hesitate in sending people for assessments and so on.

The Chair: I just want to make you aware, Mr Brown, that you've got about 10 minutes left. So you can use it as you see fit, okay?

Mr Brown: Okay. In that case, I will move on to the issues more relevant to our workers. I want to go to page 25, schedule J, the amendments to pay equity, and complete from there.

Bill 26 amends the Pay Equity Act. Effective January 1997, it repeals the proxy provisions. An estimated 100,000 low-paid women in such areas as nursing homes and day care who work for employers with no male-dominated job classes will have their right to fair pay abolished. The pay equity increases that had been agreed to for several thousand nursing home workers in this province prior to the repeal of the proxy provisions were modest at best. The repeal simply punishes these working women that were at the lower end of the economic scale to begin with.

Schedule Q contains amendments to a number of acts involving interest arbitration. Our particular concern, of course, is the Hospital Labour Disputes Arbitration Act. The bill amends legislation governing interest arbitration in the fire, hospital, police, public service and school board sectors. Previously, the Legislature determined that,

given the essential nature of the services provided, the terms and conditions of collective agreements must be determined by a process of compulsory interest arbitration rather than through recourse to strikes or lockouts.

The traditional criteria used by arbitrators to determine wages in the public sector is comparability with employees performing similar work for the same employer, with other employers in the public sector or with employers in the private sector. This ensures that wages for employees governed by interest arbitration in the public sector follow freely negotiated settlements in those sectors where the parties have the right to engage in free collective bargaining and with the right to a strike or lockout.

However, Bill 26 requires arbitrators to consider certain criteria when making decisions. These criteria include the employer's ability to pay in light of its fiscal situation and the extent to which services may have to be reduced if the current funding levels are not increased. One of the fundamental objectives of interest arbitration has been to replicate as closely as possible the results of free collective bargaining without having to worry about work stoppages or strikes or lockouts in those essential service areas. The requirements imposed by Bill 26 on arbitrators will make it impossible to achieve that result. With the requirements of this bill, arbitrators will be nothing more than agents of the government sent out to implement government budgetary measures. Arbitrators have historically held that such workers ought not to be required to work at substandard wages and working conditions because of government budgetary decisions. It will be virtually impossible to protect public sector workers from such a plight with these new requirements imposed on arbitrators.

There is a common acceptance among arbitrators and labour relations experts that arbitration boards must be independent of pressure or guidance which could skew their reasoning in favour of one party or the other. The award should result in something both parties to the collective agreement feel represents a balance of their interests. It is up to the arbitrator to independently weigh the evidence presented by the union and the employer and to come to a decision.

The criteria in schedule K constitute a significant interference with the independence and integrity of the arbitration process, requiring boards of arbitration to consider government criteria in awarding collective agreements. Arbitrators have stated that basing an award on ability to pay could render the interest arbitration process largely irrelevant, since the use of ability to pay could allow the government and employers to unilaterally determine wages and benefits by simply allocating a fixed or reduced amount for employee compensation in their transfer payments or budgets. It also would undermine the independence of arbitrators and the integrity of the arbitration process.

With that, I'll go to the last page, the conclusion, and try to leave a few minutes for questions.

The information contained in this submission pertaining to the legislation and its effect is based on documentation provided by the Ministry of Health, the Ontario Health Coalition, the NDP Ontario caucus, Ontario Coalition of Senior Citizens, the Ontario Federation of

Labour, the law firm of Sack Goldblatt Mitchell for the legal opinion on Bill 26, and various newspaper articles.

The opinions expressed are those of this union and in support of opinions expressed by the Ontario Health Coalition, the Ontario Federation of Labour and others who have made presentations. Due to constraints of time and resources, we have touched only on the particulars of the legislation we find most troubling.

We believe the impact of this bill is much too broad and far-reaching to be dealt with in a single piece of legislation, and that at the very least it ought to be broken down into three or four more manageable parts, and that public consultation of several months ought to be held on each of those parts. Ontarians deserve that much before such institutions as hospitals and other health care facilities and in fact our entire health care delivery system is so fundamentally altered and in some cases dismantled.

The Chair: Thank you very much, Mr Brown. You've left these politicians with their biggest challenge ever, and that is an opportunity at one short question.

Mr Rosario Marchese (Fort York): Mr Brown, thank you for your thorough presentation. You covered my question to some extent with your last remarks. It seems to me quite clear that when the public has an opportunity to respond to this bill, they have a great deal to say, and you, along with all the other deputants, have had a great deal to say.

There's nothing wrong with governments proposing things. There's something definitely wrong with governments trying to shut out the public from speaking to those proposals, and that's what this government tried to do. Do you believe that people have had an opportunity, obviously, to review this document or do you think—and I think you've answered—there's definitely more room for people to read this document and respond to it?

Mr Brown: I wonder if the people closest to it really understand the full implications of it. I know I've spent a lot of time on it in the last couple of weeks and I'm sure there's more to it than I've seen. But I agree wholeheartedly that we're down a path that very few people understand.

Mrs Janet Ecker (Durham West): Thank you very much for a very detailed presentation and brief. Under previous governments we've closed, according to some estimates, almost 9,000 beds, the equivalent of 30 small hospitals, with the resulting layoffs. That has been done through funding cutbacks, the closure of the beds, with previous governments. Do you believe that's the appropriate way to restructure the health care system, or do you think it would be more appropriate to restructure it based on locally planned restructuring plans and recommendations?

Mr Brown: Well, I think in the examples of the areas where we're working, there is a lot of local planning. In Essex county, Kent county, Lambton county there have been studies of the hospitals. The labour movement has historically supported true health care reform, and we certainly have pointed out over the years to all three governments in power where there are waste and inefficiencies in the system that could be eliminated without impacting on the quality of care.

Mr Dwight Duncan (Windsor-Walkerville): I wonder, Ken, if you could just go into, for the members of the government, what happened with our reconfiguration, where it was when this government took office, and why your union can no longer support the process, and delve into your answer a little further.

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Mr Brown: As I indicated in my presentation, it was not without our difficulties with the principals here in working with the DHC. We had a lot of problems along the way, but it was a locally driven process where we had input from virtually all stakeholders in the system, including the community, the hospitals and workers.

Where it really came off the rails and where the labour movement decided to walk away from it was because of the attitude of this government that after three years of planning for what we had to do in the reconfiguration process in order to save an estimated \$25 million a year in hospital budgets, there was a capital expenditure involved, and the attitude of this government was, "Those capital dollars have to be reduced." We weren't told by what amount, just that they had to be reduced: "Come up with a new plan." They wanted us to redo something that had taken three years to put together, put a couple of artificial deadlines on us to come up with something new, and then at the end of all of that, after rushing us into something last fall, as I understand it there is still no formal answer as to where we are with that.

So we were at the local level with a commitment to the capital funding necessary to save those dollars; we were moving along and overcoming our difficulties. When the government came in and put the capital funding in jeopardy, the process, from our perspective, became one of implementing saving money and not focusing on the other aspects that we were about, which was enhancing our ability to deliver care and do it more efficiently.

The Chair: Thank you, Mr Brown. We appreciate your presentation. I just want to assure you that the committee will read those parts of the brief that you didn't get a chance to go through this morning.

HÔTEL-DIEU GRACE HOSPITAL

The Chair: Our next presenters are from Hôtel-Dieu Grace Hospital: Armando DeLuca, chairman of the board. Good morning, gentlemen, and welcome.

Mr Armando DeLuca: I'm chairman of the board at Hôtel-Dieu Grace. I've served on the board since 1988. The material is being circulated. It's rather succinct. It covers two main points which we would like to make today.

I've been chair since April 1, 1994. That's the day that ministerial approval was reached with respect to the alliance agreement between Hôtel-Dieu and Grace. This is important in terms of our being here. As a community volunteer, I feel I'm part of a large number of volunteers who donate their time and energy to ensure that hospitals are responsive to the communities they serve.

I'd like to address the committee on two general areas: the need for hospital restructuring, and a more equitable distribution of health care resources, particularly in our community.

The hospitals in Windsor and Essex county, as has already been pointed out, recognized the need for hospital restructuring in 1991, when the hospitals supported in principle the vision statement which was prepared by the hospitals in collaboration with the Essex County District Health Council. The conclusion reached was that Windsor and Essex county would be better served by two state-of-the-art acute care hospitals rather than the existing four.

As a result of the studies conducted in collaboration with the DHC, the hospitals agreed to pursue voluntary mergers and alliances consistent with the plan approved by the DHC and the Ministry of Health. As a result of this voluntary agreement, the city has two hospital organizations on four sites. Once the necessary renovations and constructions, as recommended by the hospitals and the DHC, are completed, we will be able to voluntarily close two acute care hospital sites in this community. This remarkable achievement was accomplished through extensive collaboration and participation by community volunteers, front-line workers, hospital boards and the DHC. It was done without the need for a hospital restructuring commission.

We do recognize, however, that in some communities voluntary agreements may not be possible and the powers of the restructuring commission may be required as a last resort. We are pleased that the powers in section 6 of schedule F are time-limited for four years and will end on March 31, 1999. The statute will assist in hospital restructuring while at the same time preserving for the future the fundamental principle of voluntary governance.

We have also reviewed the Ontario Hospital Association recommendations 1 through 10, and they're appended to the material, and these were presented to you on December 18, 1995. We concur with all of those recommendations, including the provision "that the statute make it clear that the minister's decision to close or amalgamate a hospital is based on the public interest"—those are not little words but very important words—"and that his power to close or amalgamate should be exercised only after receiving advice from a district health council or other planning body. As part of the planning process conducted through district health councils, hospitals must have an opportunity to submit their views and be heard."

The next major point in our submission is on the more equitable distribution of health care resources. The material will show that by comparing Windsor-Essex county to southwestern Ontario and indeed the province, we haven't fared very well.

The success of hospital restructuring which will result in the voluntary closure of two acute care sites in Windsor will depend on the timely approval of the \$72.4-million capital plan which has been recommended by the Essex County District Health Council and the hospitals. This capital investment will provide for the necessary building renovations and new construction to accommodate emergency departments, critical care areas, ORs, renal dialysis, perinatal care and diagnostic services. The existing acute care buildings cannot accommodate the additional patient workload without this construction.

This committee should note that hospital restructuring provides an opportunity for equitable distribution of

resources. Although Essex county has a high incidence of disease compared to the rest of the province, it has one of the lowest per capita operating expenditures in the province. The chart shows that southwestern Ontario is 12.8% above the cost per capita in Windsor and Essex county over the last 10 years. The disparity increases from 1983-84 to 1988-89, yet even with these low per capita operating costs, Essex county refers only 5% of its population to teaching centres because we provide many of our own tertiary services such as major trauma, neurosurgery, neonatal intensive care and cardiac catheterization.

In addition, with respect to capital spending for hospitals we are also below the average compared to southwestern Ontario and the rest of the province. As you can see from the chart, Essex county spends \$200 per capita compared to southwestern Ontario at \$410 per capita. We therefore urge the committee to support the capital investment needed for hospital restructuring in Windsor, which would not only achieve the closure of two acute care hospitals but would also help to offset the imbalance of hospital capital investment in this community compared to the rest of the province.

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We'd like it to be noted that we support the Minister of Health's statement to redirect savings from hospital restructuring to community programs, based on provincial priorities and allocated through the Ministry of Health rather than through a local allocation process. Recognizing that Essex county has one of the lowest operating health expenditures in the province, additional investment in community health programs should be based on the needs of the population and current expenditures compared to other communities in Ontario. Windsor and Essex county should receive its fair share of operating dollars. We know that those needs will be considerable in the community program area.

Thank you for this opportunity to address you. In the event you have any questions, I am here with Mr Bagatto, who is the CEO of our institution. Someone in the audience asked that we speak on behalf of the other institution as well. We'll do our best.

Mrs Helen Johns (Huron): Thank you very much for your presentation. I appreciate your being here today. Having lived in Windsor for a few years, I know that the hospital system and the health care system here have special needs as a result of being a border town also. I appreciate your time in talking to us.

I was wondering if you could just comment on your charts on page 3 for a minute. Can you tell me why you're using data from the 1980s and, at the latest, 1990? Can you tell me the formulation that went into those charts and why those numbers are from that time frame?

Mr Frank Bagatto: We took that information from the Orser commission. That's the only information we have. I've been encouraging others to seek that kind of information, because I think it's vital to the community. But obviously we don't have the total picture, so we relied on the Orser commission for the data.

Mrs Johns: Can you tell me, from your gut feeling and being in the community, would the data that we would present, looking at 1994-95 data, be somewhat the

same as this or are there major changes within the time frame of five to six to seven years?

Mr Bagatto: Without giving evidence, so to speak, from my information I can confirm that it would probably be an increasing disparity, given the accelerated increases in complexity of patient care that we're providing in this community.

Mrs Johns: Last week we were in Timmins, Thunder Bay and Sudbury, and this week in Windsor. Those four geographical locations are basically forerunners in the hospital restructuring, having their DHC reports done and starting to combine services in areas. I was interested that you said you believe that some communities would not be able to come to agreement and we needed to have those powers. Can you tell me why you believe that, or how the process differed in Windsor, that you got community approval and other places may not?

Mr DeLuca: We all know what we read, and we have a sense from what we read that the difficulties in Toronto, for instance, will be considerable and the process may drag on. The commission may be helpful in moving that process along more quickly.

Mrs Johns: So as much as the commission may not be needed here, you can see times and time frames where it may be needed.

Mr DeLuca: Perhaps.

Mrs Ecker: Thank you very much for your presentation. Coming from a region that actually has lower per capita health spending than Windsor, I can appreciate—in ours the problem is due to the growth we have in our particular region. As you note, you have unique needs because of the disease rate you have here. I think that underscores what's very important about the fact that there are unique needs region by region.

I would like to just mention that while the legislation, Bill 26, does repeal section 8, and I know the previous speaker had mentioned this, subsection 8(1) of the old Public Hospitals Act, which does have the district health council powers and recognition, is still in the legislation, because we quite agree that those regional restructurings, based on local recommendation, are very, very important. What was the secret of your success in terms of being able to get consensus?

Mr DeLuca: I think that's so. Labour, at least in our institution, was very much a part of the process. From the beginning, we involved our front-line workers. Mr Brown and a number of his colleagues as well were present at town hall meetings; he wasn't at our institution, but Mr Bagatto had town hall meetings weekly in the hospital. One of the fundamental principles we articulated was that we hoped to achieve the downsizing without impacting the lives of the health care workers who had chosen this vocation as their life's work. We thought we could do it with attrition and early retirement and without impacting the workers who keep the institutions going, and there are thousands of those. That, plus an enormous amount of goodwill on the part of the volunteers, who devoted countless hours to this very commonsensical approach to reducing from four acute care sites to two and the efficiencies that would flow from that.

Mr Crozier: Mr DeLuca, I need your help on recommendation 1, where you agree with the OHA. Many of us

agree with sunset clauses for a wide range of legislation, but I need the reason why you support this clarified for me. You say: "In this way, the statute will assist hospitals and the government in the restructuring of the hospital system, yet at the same time preserve for the future the fundamental principle of voluntary governance."

If you believe in the principle of voluntary governance—I might compare it to, if you believe in the principle of democracy—why would you agree it could be suspended for four years and then brought back?

Mr DeLuca: In our view, there's a reaffirmation of voluntary governance in that it has a built-in time frame. It may be, provided that the public interest is maintained throughout this interim period, that the process, the savings, will be moved along a little more quickly than they might otherwise be, without sacrificing the public interest, yet we're coming back to the same system of voluntary governance. It isn't off the table totally.

Mr Crozier: You just don't have any for four years.

Mr DeLuca: I wouldn't go that far.

Mr Bagatto: The intent—hopefully, and we have no guarantee—is that if there's stalemate in the community, which is not the case in Windsor, maybe this commission's powers would be used very, very sparingly. That's our hope. Maybe it's naïve on our part, but only when there's a stalemate and nothing is moving.

Mr Duncan: You gentlemen were so integral to the reconfiguration process in this community. Would you be concerned if there was a loss of local ability to deal with these issues? Would you reaffirm today that a locally driven solution is indeed a better solution?

Mr DeLuca: Yes indeed. I would.

Mr Duncan: Any advice to members from communities that haven't gone through this process about the pitfalls and things to beware of in the reconstruction process?

Mr Bagatto: In my view, the most difficult problem is time. In this community we started in 1991, and I don't know how other communities will deal with the major operating dollar reductions without a restructuring plan. This is why we need a restructuring plan to be implemented, so we can achieve the budget reductions that will be imposed on us through this government.

Mr Duncan: So there are going to be budget reductions imposed by the government? We were told there wouldn't be.

Mr Bagatto: We're going by the Treasurer's statement.

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Mrs Pupatello: The Conservative members keep mentioning the DHC and how the bill doesn't change its role. The reality is that the DHC never did have legislative power, nor is any given or taken away, although the Minister of Health is on record now as saying that the DHC will be reverted in terms of its advocacy role, that it's going to be taken away or is going to be told it's doing even less. How do you feel, given the role it played in the restructuring in Windsor-Essex county?

Mr DeLuca: From what I read, I hear the minister say that he sees the DHCs as advisory bodies, that they are his eyes and ears at the local level. We don't see that as changing, and we see it as helpful.

Mrs Pupatello: Do you think we're in an underserved area?

Mr Bagatto: I'm concerned that we're the community with the largest population in Canada without a teaching centre, and are two hours away from a teaching centre for tertiary services. I recognize that some centres on the periphery of Toronto are in a growing population and perhaps have a cost per capita less than Windsor. But I worked in Richmond Hill many years ago, and you're within half an hour of tertiary services. In Essex county we have a population of 350,000 people and we deserve the same level of care as other parts of the province.

Ms Lankin: Thank you very much, gentlemen. I appreciate your presentation and I thank you and others who have been involved in the process here in Windsor for the fine work you've done in that restructuring plan. I hope it proceeds to be implemented as it was planned and that the Minister of Health doesn't use his new powers in any way to impose on you solutions that are not satisfactory to your community.

I sat that and it perhaps sounds a bit facetious, but there are good reasons for it. Already we have seen the minister determine that notwithstanding previous commitments, the capital dollars commitment that would have helped the reconfiguration from four physical plants to two is gone; the commitment for the operating dollars to be reinvested in your community—even though I recognize you say "provincial priorities," but I think you're hoping you would be a provincial priority—is not rock-solid any more.

We've seen a community in northern Ontario where there was a complete and unanimous recommendation from a district health council on the issue of governance of their hospitals where one hospital had fought that all the way through; the local community had the support of the ministry and the minister previously, and now the new minister has pulled the rug out from underneath the local process and that hospital has won out.

In Ottawa, the community believes it has a process that is coming to a conclusion, but one hospital came forward to present to this committee and say: "We don't need to listen to the community. We don't need amendments in the legislation that say the DHCs should be involved. The minister is accountable; the minister should do this." And when I said, "If you can't reach a consensus in Ottawa, who should the minister listen to?" the chair of the board in that case said, "Us," a large facility.

I should say the only facilities I have heard come forward and be overwhelmingly supportive of this, all the powers being in the hands of the minister, are large specialty or teaching facilities. We know there are few in number; we know they take 40% of the hospitals budget. We know they are the jewels in the crown and are very important in our system, but we also know they get the ear of the minister. If I were a community hospital or a community service looking to see that restructuring and reinvestment from hospital dollars into the community, I'd be a bit worried about all the powers as they are and that they be used as judiciously as you are hoping they will be used.

Mr Marchese: "Don't worry. It'll be all right."

Ms Lankin: "Trust me," right? This legislation is underscored with big words: "Trust me." I have to say, with this current government, I personally don't.

In your brief you said you are pleased that the powers in section 6 of schedule F are time-limited for four years. In general, you're looking for sunset of powers. The minister has indicated that he will sunset—if we ever see the amendments—the Health Services Restructuring Commission. We believe it is necessary that the extraordinary powers be sunsetted, and I think you are indicating support for that.

Specifically, I would like to ask you about a couple of amendments we've been trying to convince the government it should consider. As to the power of supervisors to go in and take over hospitals, where it's in a closure situation perhaps those extraordinary powers you would support. Where it's a question of the quality of care or concerns around that, do you not think the due process of an investigator's report and an opportunity to respond should be maintained? And would you comment about the issue of the Minister of Health being able to impose physician resource plans on hospitals, which seems to me to be a little too much micromanagement.

Mr Bagatto: We're concerned about that; in the interests of time, we didn't want to repeat the submission made by the OHA. We're concerned about extending the powers of a supervisor, really suspending the powers of volunteer boards based in the community. Those powers should be sunsetted as well, if they're going to be implemented. In essence, we're concerned that the volunteer hospital boards are responsible for the quality of care, yet a supervisor can overrule that responsibility. They're accountable, yet the supervisor can make changes and not be accountable. We're very concerned that they're not legally accountable.

Ms Lankin: You indicated that you support the concept of hospital operating dollar savings being allocated based on provincial priorities, but you do stress an investment in community care. We have seen some mixed response so far from the government. Not a lot of what they're taking out has been earmarked for reinvestment, but even at that, for example, one of the areas of reinvestment was in cardiac surgery. I don't know this to be true, but I will tell you that three people in the health care, hospital sector have told me the government got duped big-time in terms of the cries from the cardiac network—you know, that sometimes high-tech, powerful voices get the money. That's not exactly reinvestment in community care. I'd like you to talk about that, because I worry when it's provincial priorities that the squeaky wheel gets the grease.

Mr DeLuca: I know Frank will have more to say, but the minister had published in our local paper a letter responsive to this question. As I read his statement, he was focusing on community issues across the province as opposed to reallocation at a local level.

Mr Bagatto: Determination of need is vital, and it has to be done with the medical profession, the employees, the community, and it can't be done arbitrarily; it has to be based on data from district health councils and the work being done across the province to determine, what are the population's needs? Again we're hoping for objectivity in determining those needs.

Ms Lankin: You have a lot of hopes riding on this, let me tell you.

The Chair: Thank you very much, gentlemen. We appreciate your being here with us this morning.

The Chair has had one too many cups of coffee this morning, so I'm going to have to take about a three-minute recess.

The committee recessed from 1028 to 1032.

The Chair: Okay, folks, the emergencies have been taken care of so we can get back to work.

ASSOCIATION FOR PERSONS WITH PHYSICAL DISABILITIES OF WINDSOR AND ESSEX COUNTY

The Chair: The next group is the Association for Persons with Physical Disabilities of Windsor and Essex County. Good morning, sir, and welcome.

Mr Taras Rohatyn: Thank you very much. Good morning, ladies and gentlemen. I am the executive director of the Association for Persons with Physical Disabilities of Windsor and Essex County, more commonly known as the APPD.

We appreciate that the association has been allowed to present its concerns to this committee, and I ask the committee members to refer to the brief distributed by the clerk. Of course, I will not read the entire presentation but will highlight a number of elements, issues, and association programs. I will present a number of individual case profiles to you and in each case demonstrate the effect of the changes contemplated through Bill 26 and the diminished quality of life that will ensue. To conclude our presentation, I will then refer the committee members to a series of recommendations that we truly hope will be considered by the committee.

In order to understand our association, I wish to very quickly highlight 57 years of history. I'll do that in two paragraphs. I refer to page 2 of our brief, specifically the last two paragraphs.

The APPD was formerly known as the Cerebral Palsy Association and has had a varied history since its inception in 1938. We have been a strong community player since that time. In the early 1960s we took over an existing workshop from the March of Dimes, renamed it in 1978 to be called Participation Industries, in advance of Participation, and we relocated to a 25,000-square-foot facility in that year. The board realized very early, and they were very proactive, that the workshop, as it existed, was not beneficial to a number of individuals who wanted to work in society. With an agreement with the General Motors of Canada transmission plant, we actually created a business called Participation Press Assembly Centre, or PAR PAC. In 1987, that business received the quality of excellence award for its small parts production.

During those 10 years from 1981 to 1991, we had significant growth also in our residential programs. We were the first in Ontario to create what was called an independence training department program—a life skills program where people learn how to live in an apartment and move to a community.

In 1984, we commenced an outreach attendant care program—workers going into a person's home, assisting them with their activities of daily living.

In 1991, the flip side of it: a respite program to give the caregivers relief.

In 1994 and 1995 we expanded our services into supportive housing.

Specific details of our vocational residential programs are outlined in the brief and are expanded on, and I do not wish to go through them today, but they are on page 3 through to page 8.

We employ 130 personnel today. We service nearly 250 adults with physical disabilities with their activities of daily living, but unfortunately we also have approximately 250 individuals on our waiting lists.

I ask the committee to turn past the appendices. The appendices are very specific. For those who may not have had the opportunity to deal with our particular types of services, they deal with activities of daily living and provide definitions on what has been accepted by both the federal and provincial governments as definitions in dealing with disability issues.

We'd like to highlight, however, a number of individuals we provide services to currently, and there is a variety of them. I'll provide you with a very short little background and then indicate to you what the potential effects of Bill 26 will be on them.

The first, and I will not go through each one, we've initialled as B.D. I'll call him Brian for the sake of a B at the present moment. He's a male who's 28 years old with spina bifida. Medically, he's susceptible to skin ulcers, urinary tract problems and a history of kidney stones. Overall, his income for the entire year through FBA is \$680 a month or approximately \$8,160 a year. I challenge anyone in the room behind me and in front of me and to the sides of me to attempt to live on that income. However, Brian has done reasonably well.

Brian is very, very involved in recreational activities in the city. He in fact may end up on the Olympic team for people with disabilities in weight-lifting, and that is his second life. His first is his desire to work. Brian had the opportunity through our supported employment program to find a job in the community. He did extremely well; in fact came off of FBA and became a taxpayer. Unfortunately, and it had nothing to do with Brian nor did it have anything to do with the job, this major national chain had to lay off that particular division across Canada and Brian was affected, like everyone else was. Brian had to come back into the system, had to go back to where he was, and that hurts. His quality of life diminished fairly substantially.

What we envision, unfortunately, with some of the contemplated changes and some of the discussion, and again not all of it is known, nor is it fact at the present moment, but because Brian is involved within the health care system through prescription drugs, through the use of the health facilities, if there are additional costs, whether they be called copayments or whether they be called user fees, whatever the terminology itself, it will adversely affect that \$8,160 a year that he already has.

1040

There are other ramifications also. Indications already are, locally, that there are changes to the parallel Handi

Transit system; that there is a diminishing of hours of service; that there is a diminishing of the number of rides available because of potential budget cuts, nor do we know whether it is through the transfer payment process, whether it is at the local level or whether it is a decision. However, there have been changes.

I challenge anyone—should they wish to leave today and pick up a taxi and go home, they can do it. In some instances with the parallel transit system, you have to book a week to two weeks in advance to go out with the boys for a drink. That is not acceptable. If there are additional fees imposed, if there are increases in the transit fare, if there is a diminishing of services—not 12 o'clock midnight pickup, but 10 o'clock—quality of life will be diminished.

I would ask committee members to refer to the second individual profile. This is a young lady, a female, 28 years old, S.L.—“Susan” for the sake of a name at the present moment—who is a quadriplegic with some upper trunk and limb control. She also has a problem with a urostomy. We provide you with a brief description of her medical situation, her income and her accommodation.

She lives in a supportive housing complex, where her personal activities of daily living and attendant care needs are supplied for by our association. She's a very interesting young lady, who became employed this year. After 30 years of living at home, after being taken care of by her parents, she had moved off into the community, was able to upgrade her grade 7 education over the last few years, received her high school degree and then became employed. Unfortunately, it was with one of the crown agencies that has been disbanded locally, and that income has been lost to her. It was her first real job. She would like to move on in school. Unfortunately, there are many barriers, obviously, in the education system, from the beginning right through to the higher institutions of learning.

She uses a large amount of prescription drugs to maintain her medical health. Because of a lack of income in the process of moving from gainful employment to UIC, she will go back into the family benefits, the Gains-D. She will be back at a level of \$8,000 to \$10,000. Any \$2 additional copayment, user charge, will have a negative impact.

She also falls into the process and the problem of the parallel transit system. That is her only means of transportation. She is actively involved in numerous committees, advocating very strongly on disability issues both locally and provincially. Again, if there are additional costs, if there is a minimization of service, it will affect her life dramatically.

She would like to be re-employed. She would like to move on in education, but she realizes that she has to have additional education. If there are increases in tuition fees and there is no reciprocal funding available through any kind of source, she will not be able to move forward. We provide a summary of her potential and of the problems that we have and that she has in the general summary.

I'd like to skip by the next case profile and move on to one individual we have. The second line indicates “Independence Training Apartment Program.” M.L., 34,

female, left-side stroke, left hemiplegia. This young lady was gainfully employed with the city for a number of years. She has a degree. Unfortunately, a tragedy occurred: a stroke which left her with severe physical disabilities. This is not out of the ordinary in our world.

She has, and had, a fairly substantial income. She has disability pension coming in and Canada pension plan. So she falls well above the norm for general benefits or Gains-D. That income excludes her for a number of things. What she would like to do is get back into the life that she had previously, and the chances are slim to minimal.

However, her major goal is to walk again, and I think that is very important to her. We've brought her, fortunately, into the system in a non-subsidized apartment and are retraining her in the life skills that she lost because of her stroke. Part of the problem is that should she succeed within our training apartment program, she will go on a very substantial waiting list for supportive housing programs. She will require attendant care services, probably over a 24-hour period, and the list itself is very, very dramatic.

She now has to use the parallel transit system, and again, I've indicated to you the problems that are occurring and that potentially will occur. Her needs for prescription drugs at the present moment are quite dramatic. She is one of the few who will probably be able to afford, because of her disability, through the insurance that she is receiving, to pay for a portion of it. However, at a point in time, that will run out. She will still have a relatively substantial income, but the \$100 deductible and the pharmaceutical fees will have an effect on her life.

The last two individuals I would like to speak of are under our central Y housing supportive program. If you see, I'm leading you through our programs and where the individuals themselves are and what the impacts will be.

C.K.: We'll call her Cindy. She's a 39-year-old female with an arterial malformation and uses a manual wheelchair. She takes six different medications and independently pays for supplies for urinary problems, and the six medications are on a monthly basis. This does sustain her, without any question. But the additional cost of the urinary supplies because of the urinary problems is fairly substantial. Quite a while back, a lot of this, through the ADP, was covered. That has disappeared. Our local social service department had an emergency fund for those who might not be able to afford. I suggest that within the first three months of the year that fund is depleted, and I don't think Windsor is an exception. It is just a matter of dollars.

She does reside in a supportive housing program. She came through the system, our system, the entire system, and has been able to move to independent living. We provide her with the arms, or the legs, that are necessary and the assistance with activities of daily living. She attends swimming. It is very important to her. She attends church functions. She attends special events that we hold in the community halls.

If the transit system is to increase costs and diminish its activity, that will have an adverse effect on her. If transfer payments are reduced and municipalities are put into a position where they have to bring in some type of

fee for recreational facility usage, this will affect her life quite dramatically. She would like to move on to an additional, a different, supportive housing unit, but unfortunately again, there is not an availability within the city or within the county.

The last individual I would like to refer to is two pages over. This is an individual, G.B., in the attendant care outreach program. She's 39 years old, chronic leukaemia, osteoporosis, osteonecrosis—there is a definition of what osteonecrosis is—and spinal damage. She lives with her son, 10 years old, in the county. She was widowed in 1991 and she has no other family. She supports herself and her son through FBA, the Gains-D, and in 1992 her gross monthly income was \$1,014 a month. Again, we're dealing with an individual with about \$12,500 in gross income. She's permanently disabled because of her condition.

She is attempting to have increased homemaking because her condition is disabling and in fact is degenerating, and receives approximately 12 hours weekly through the home care program. There are quite a number of personal goals, and one of the most important in dealing with quality of life is functioning at the optimum level that she can. She wants to care for her son, but there is a question mark at this present time of a 10-year-old boy and a mother who may not have the services available to her to move forward. She'd like to remain independent in her own home. She'd like to have an increase in the outreach attendant care program, activities of daily living, and additional homemaking. Those are not available because of substantial waiting lists.

1050

The problems themselves are a little more systematic in this particular case because there is a very large demand for the services that we provide, like organizations across the province, but at the same time the question mark of where some of the dollars will be coming from. We have heard very, very strong statements that there will be a reinvestment in community; however, there have been a number of questions raised in the process itself. If the reinvestment does come, we will be more than happy and willing to accept it because of the people who are waiting.

I would like to ask committee members to refer, on the grey sheets, to the recommendations that we have. There are only six. They're very broad and they're very general. We could not be as specific as a local association. We don't have the resources to read through 2,000 pages, but we at least have the 211 pages that we're able to refer to.

We ask that the committee recommend to cabinet:

—That there be an extension of the time frame proposed for the enactment of the bill to allow for further discussion and dialogue regarding the impact and consequences, and specifically for our group, for persons with physical disabilities. We deal with the adults.

—That serious consideration be given to excluding or exempting all adults with physical disabilities from all aspects of Bill 26 whose gross income is less than \$25,000 a year.

—That serious consideration be given to including provisions which will not allow municipal or other government or regulatory bodies to impose, in the

broadest sense, fees on adults with physical disabilities whose income level is below \$25,000. I just refer, as examples, to libraries, recreation, refuse collection.

—That serious consideration be given to provisions being included in the bill that ensure that transfer payment reductions stipulate and guard against any reductions being directed to local parallel transit systems for persons with physical disabilities.

—That serious consideration be given to the enhancement of funding levels for supported employment programs which in the longer term will provide work opportunities and the entitlement of paying taxes for adults with physical disabilities.

—That serious consideration be given to the enhancement of funding levels for supportive housing programs and second-stage housing for battered women with disabilities, whether by delaying or deferring action on provincial housing authorities or the not-for-profit housing sector, or by providing appropriate incentives to private landlords to build new apartment complexes or renovate existing apartments to barrier-free units for adults with disabilities.

Ladies and gentlemen, 16 out of every 100 Ontarians have a physical disability. Statistically, looking at the committee makeup, a minimum of two of you will require within the next decade the services that we provide as an association. You may today be comfortable with your income level and options concerning your quality of life and that of your family. However, the future for each of us is unknown. You may conceivably become a case profile study, as presented today, in the not-too-distant future.

We realize the provincial debt is an enormous burden on each citizen, but we ask that you be sensitive to those who will be dramatically and adversely affected by the proposed changes through Bill 26.

A Chinese proverb suggests: A man who removes a mountain begins by carrying away small stones.

Mrs Pupatello: We heard from those representing persons with physical disabilities during the general government committee hearings on employment equity. It was interesting that they mentioned that every one of us is only years away from having some form of disability ourselves in terms of things that happen to us as we get older.

They also mention that of all they see the government doing, it's especially hitting those with physical disabilities, whether it's through those on welfare, the housing cuts, the housing projects that have been cancelled, especially those with supportive housing. That wasn't given any additional look; that was cancelled outright. There's the second-stage housing for battered women, because so many of those women are disabled. There's a high incidence of abuse among disabled women. And of course there's the employment equity that was thrown out outright. How do you see that in comparison to the sweeping things that affect those with disabilities in Bill 26?

Mr Rohatyn: I think they're parallel, but I also think there has to be consideration for each specific process that we're talking about.

With the process of employment, I think one has to consider that if the proper services are available, if the

proper backup is available, what you will end up with is a working Ontario, off of benefits, off of disability pension, and providing income not only to themselves but, through taxes, to the province of Ontario.

It is difficult to be able to say that there is an equality within the system itself. This goes back for generations. This is not an issue of just today or just of what has happened in the last little while.

Individuals want to work, but individuals with disabilities are the same as anyone else: Some will, some won't, some do and some don't. If the mechanisms are not available within the education system to provide them with support, if the educations are not available to them in institutions of higher learning, through colleges and through university, and if they are not available within the workplace, then individuals with severe and moderate physical disabilities have no chance of employment, not only yesterday, but in the future. I use that as an example specifically. There are many, many other issues besides.

Mr Marchese: I have two questions, Mr Rohatyn, if I can get through them.

The first one has to do with the kinds of things the Conservative government has said with respect to employment equity and, as well, the Advocacy Act. With respect to employment equity, they said it was too intrusive and it was too draconian. They're about to repeal the Advocacy Act that we passed because they argue it's too intrusive and it's too draconian.

It's incredible to me that they can say that about other bills and at the same time introduce a bill that is the most dictatorial bill that we in the House have ever seen. Not only does it give powers to ministers to close or to merge or to make other directions with respect to hospitals, but it absolves them of any responsibility, and the scrutiny that we wanted was almost abolished had we not done what we were able to do here, giving people an opportunity to do this. Do these powers give you any comfort whatsoever?

Mr Rohatyn: I think we have to be very cautious in almost anything. I would like to suggest that when the entire employment equity was brought forward, we did speak to it and the Chair at that point asked, "What do you want?" I said, "Let's not be passive. If you want quotas, put them in writing," and we in fact suggested that the quotas be in writing, that there be a percentage of employment which includes people with physical disabilities, and then we defined for that minister and that Chair at that time what our definition of "physical disability" was. We were quite specific on that.

Mr Marchese: I wanted to make a statement then to remind everybody that in the Common Sense Revolution they indicated that seniors and people with disabilities would not be affected. We have seen in many ways that they have, and this bill proposes a user fee that will affect seniors in a very big way and affect people with disabilities in a serious way as well.

Mr Rohatyn: That is why we in fact raised the individual issues from the various programs that we have.

Mr Clement: Thank you very much for your presentation. I note that your organization is funded by the Ministry of Health, I think to the tune of over \$2 million a year, and that you're also funded by the Ministry of

Community and Social Services. The figure I have is over \$450,000. Is that fair to say?

Mr Rohatyn: Correct.

1100

Mr Clement: I find that interesting, that you've got two different ministries doing funding for particular programs and then you've mentioned with the case studies how your clients intersect with Health, with Housing, with women's issues.

I'd like to put this question to you. I wonder whether you'd like to expand your recommendations a bit, because it seems there's a whole bunch of different ministries interacting with your organization and with your clients. Is there perhaps a way to restructure the way government does its job so that more of the money actually goes to the individuals affected rather than some of it perhaps getting taken up by overadministration and overcompliance and what have you? Is that something that you've turned your mind to?

Mr Rohatyn: There has been, in fact, a series of actions that have occurred over the last little while where government has moved to individualize funding for attendant care services. It's a pilot project at the present moment. I think for a segment of society it will be quite beneficial, but that individual must be a doctor, a lawyer and an Indian chief in that whole genre of what is being said, to be able in fact to be an employer, and that is not fit for everyone. They become an employer of their attendant services and they fall within all the legal liabilities and ramifications that follow as an employer. So it's a small group of individuals who would be able to benefit from that.

We are multiminsty-funded. There are more funders than just the ministries themselves, United Way included, and there are our businesses. So we have a variety of funding and dollars coming into the association.

The problem is that our recommendations were fairly broad because we, unfortunately, didn't have the time, nor do we have the resources, to be able to get into the detail. We will be submitting, hopefully through the board of directors, further recommendations through the committee itself for scrutiny in the future.

The Chair: Thank you for your input. We'd be happy to consider any recommendations you forward to us.

Ms Lankin: Mr Chair, with that suggestion to the individual that we'd be glad to consider those further suggestions, you'd better get them in by the end of this week because we start clause-by-clause next Monday and a week after that the whole bill's passed.

CANADIAN AUTO WORKERS-CANADA

The Chair: Our next presenter is from the Canadian Auto Workers, Peggy Nash, assistant to the president. Good morning and welcome to our committee. You have a half-hour of our time. Questions, should you leave the opportunity for them, would begin with the New Democrats. I'll ask you to identify yourselves for Hansard and then the floor is yours.

Ms Peggy Nash: I'm the executive assistant to the national president of the CAW. With me is Catherine Gilbert, legal counsel to the CAW national union. You're

being handed now a copy of our brief. I'll be referring to the brief but I will be making other comments as well.

The CAW is well known to the community of Windsor. We represent more than 200,000 members across Canada, about 130,000 in the province of Ontario, and in addition about 40,000 retired workers throughout our union.

The issue of health care is fundamental to working people. To be free of the fear of losing everything as a result of catastrophic accident or illness and to have more or less equal access to quality health care regardless of income have been of central importance to workers' lives over the last three decades.

As early as 1950 our union negotiated medical, hospital and surgical insurance in Canada. We were the first to do so. This was followed in 1968 when we first negotiated dental insurance. Both of these developments set the standard for group prepaid health care. However, we believe strongly in a universal health care system. We don't believe that the provision of health care should be tied to one's place of employment.

The dramatic policy changes contained in Bill 26 constitute a major and disturbing threat to working and poor people in this province. This bill aims to undo social advances that working people have achieved throughout the 1960s and 1970s. At stake are the living standards and the basic security of our members along with those of thousands of other working people in this province.

This government seeks to make these extraordinary changes without proper public debate and consultation and without the mandate of the people of Ontario. The Tories in their Common Sense Revolution promised to protect health care, and we don't believe that that's what's happening with Bill 26.

Our presentation deals with three areas. The first is the issue of democracy. We ask the question, what's happening to democracy in the province of Ontario?

In the Common Sense Revolution document you said, "The political system itself stands in the way of making many of the changes we need right now." We think they were prophetic words. The entire process surrounding the introduction of Bill 26 has revealed this government's contempt for the democratic system in this province.

We want to add our voice to the outrage over the inadequacy of these hearings. The only reason we're having hearings is because the opposition parties forced the government to hold hearings. We're sitting today in a packed room in this hotel. Clearly there is intense public concern about what's being proposed through Bill 26. These hearings are inadequate. There are hundreds who want to be heard and cannot be heard before this committee. We think it's a shame.

We have to ask the question, why are you afraid of debate? Why don't you have the courage to defend your views publicly? What are you hiding? We believe that the government should not be permitted to dismantle the health care system as set out in Bill 26. It should certainly not be permitted to do so by anti-democratic legislation that gives cabinet, appointed officials and ministers unlimited powers to make decisions affecting the delivery of public services and the operation of public institutions without public scrutiny, debate or community input.

Bill 26 would ensure that the public is left unaware and outside the democratic process that would allow them to even discover, for example, that they will soon pay for numerous health services, that services will be reduced or eliminated in their communities and that they'll be prevented from using services which are now universally available. We believe these proposals have much less to do with balancing budgets or reducing deficits and much more to do with Conservative ideology.

Bill 26 contains numerous schedules which involve over 40 pieces of legislation. We use the example of the bill's impact on our public hospitals to illustrate our concern about the lack of democracy. The changes contained in schedule F to Bill 26 give the minister virtually unlimited powers with respect to funding, operation, closure and amalgamation of public hospitals. Further, health care decisions once made by hospitals and communities that they serve will now be controlled by cabinet and the Minister of Health. Our hospitals will no longer have an essential independence from government.

Funding: The minister will have unlimited authority to decide all hospital funding matters. These changes clearly present the scenario that this government will find less resources available for health care because, for example, more is needed to cut income taxes for the well-to-do.

Hospital closures and governance: The minister will be able to close and amalgamate public hospitals whenever the minister considers it in the public interest to do so. Currently the minister cannot act for fiscal or budgetary reasons alone or without regard to the effect on patient care in deciding to close or amalgamate hospitals. No public consultation will be necessary now before the minister can exercise this new power.

The minister will have the power to override decisions of the boards of directors without their input. The minister will have the power to direct a hospital to provide or stop providing services. They'll have the power to dictate almost any aspect of the operation of public hospitals.

It also appears that Bill 26 may allow hospital boards to override and ignore contractual obligations, including collective agreements. This is probably in violation of international labour treaties such as ILO treaties, of which Canada is a signatory, and is absolutely anti-democratic.

Finally, throughout the health-related sections of this bill, the cabinet, Minister of Health, hospital supervisors and boards of directors are protected against any liability or court challenges. Yet the health care providers and citizens are not provided with any opportunity to have input into decision-making or any vehicle to appeal these decisions.

We understand that there are amendments being considered, especially concerning the right to privacy. We want to see any proposed changes or regulations that are being considered along with this bill. Why should we have to wait until after this bill is passed? Again, what is the government hiding? We believe this is a fundamental question of democracy and that Bill 26 and the manner in which it's being brought in is contrary to our democratic traditions.

In summary, on the question of democracy, we believe that one way or another, people will be heard, and governments ignore the people at their peril.

1110

The second area we want to address is the right to privacy. The violation of a citizen's right to privacy was not contained in the Common Sense Revolution, to which the Harris government often likes to refer as proof as its mandate from the people of Ontario.

It's hard to think of information that is more sensitive in nature than our personal medical histories. It almost defies belief that this government is actually trying to pass legislation that would override the right of citizens to have their personal medical histories held in confidence, without public hearings, scrutiny or debate. The personal information could include information from patient diagnoses, hospital records and prescriptions, such as details about mental health, medical history, ancestry, genetic makeup and more.

Citizens will have little or no recourse or protection when personal information is disclosed. This information belongs to the citizens of Ontario; it is not the government's property. We would do well to remember that it was the issue of disclosure and misuse of confidential medical information that led to the resignation of a Minister of Health in the previous government. This government is apparently seeking to legalize just such a violation of an individual's privacy by the minister.

We are also very concerned that the government seems to be intending to contract out aspects of OHIP administration to private companies. Private companies which are not accountable could obtain contracts and thereby possession of and the ability to use or disclose our confidential medical information.

After concern was publicly expressed by many, including Ontario's privacy commissioner, the minister said that changes may be made. No details have been given with respect to any measures, nor any assurances that changes will undergo public scrutiny. Again, these changes should be seen now so that they can be debated by the community, the public, before the bill is voted on.

The third area we want to discuss is the whole question of dismantling medicare, and we have to begin by asking the question, why, at this time in our history, when we are producing so much more, more than ever in the history of our society, are we eroding the programs that our parents and grandparents built?

We don't believe it's just an issue of the deficit. Banks are making record profits, more than \$5 billion this past year. Company profits all over are high. CEOs are making record salaries and bonuses. This is more about transferring wealth from workers and the poor in our society to the wealthiest in our society.

We believe that one of the greatest rights in a caring society must be the right to have decent health care. Years ago, we chose a system designed to make sure all Canadians would have universal access to health care regardless of financial resources. Medicare is perhaps our most cherished social program.

This government's Common Sense Revolution, your document, was explicit in sending a clear message to the voters of Ontario that health care would not be touched. It was described as one of the "top priorities—essential services that Ontarians want to see protected." The Harris government promised not to cut health care spending,

playing on the concerns of the population that it's far too important.

It is absolutely unacceptable for this government to attempt to change the health care system in this province to a two-tier health care system where the more wealthy will be provided with a much different level of care and treatment. The end results of these changes contained in Bill 26 are declining quality, user fees and privatization in key areas of the health system.

Medically necessary services: I want to speak to the fact that these can now be deinsured. The Health Insurance Act currently requires that OHIP cover all medically necessary services provided by physicians. Bill 26 gives the power to decide which medical services will be insured, under whatever conditions or limitations the cabinet may establish by regulation.

This power will enable the government to limit access to services which are now covered by OHIP. It may even decide not to cover some services which are now considered medically necessary but which they perhaps consider to be too expensive. The government can differentiate on the basis of any other criteria it determines.

Incredibly, the cabinet will be given the power to determine the type of services provided to persons of "prescribed age groups." What can this possibly mean? Could this mean that somebody over 65 or perhaps premature infants needing open-heart surgery would not get the services they require? Is the government now going to make value judgements based on age?

Decreasing insured services is another route to two-tier medicine. The wealthy never have to worry about a lack of universal health care. They'll always be able to afford health care. It's working people, the average person in Ontario, who need universal health care coverage.

User fees: The Common Sense Revolution clearly promised "No new user fees," but what do we find in Bill 26? New user fees and the power to create more.

Hospitals to charge patients: Bill 26 would give the cabinet the authority to make regulations to allow hospitals to charge patients user fees for any hospital-based insured service. The government did not tell the public, when introducing this bill, that hospitals could soon be permitted to charge for emergency room visits, drugs, use of operating or obstetrical delivery rooms, nursing services, tests, accommodation and meals. An administrative fee of up to \$150 may also be charged to patients.

This is absolutely unacceptable. There can be no doubt that such fees will act as a deterrent. Let's be clear: Only the poor and the working poor will be deterred from obtaining the medical care they need.

Other changes repeal the language which directed the minister to give preference to non-profit Canadian operators. This raises the real possibility that for-profit American health care providers will be licensed to provide health services in Ontario and to charge patients for this service. We're talking about bringing in Americanized health care.

This government has never received a mandate from the people of this province to launch such an attack on universal, accessible health care. It's a shame on this government that it's introducing this.

User fees for prescription drugs: Under Bill 26, the government introduces user fees and gives the cabinet the power to unilaterally increase the fees as well as to change the method by which the fees are charged.

The government tells us today that a fee of \$2 will apply. In addition, depending on income, a \$100 deductible per senior per year will be instituted for benefits under the act, plus the full cost of the dispensing fee even where the \$100 deductible has been reached. But we have no assurance that the fees won't be significantly increased tomorrow and we'll have no opportunity to be consulted with respect to such increases.

What we're talking about is another example of a two-tier health care system. First the government makes deep cuts in the income provided to the poor; then it increases the cost of their medical care.

This bill will also give cabinet decision-making authority over which drugs are eligible to receive reimbursement under the plan. Cabinet will consider any matter it believes advisable in the public interest, specifically including the cost of the drug, in determining whether to list the drug. Medical necessity or other health criteria do not necessarily have to be considered.

Where user fees were introduced in other provinces, studies have shown that visits to doctors by the poor and the numbers of prescriptions filled by seniors declined. As a result, we may find that the poor stop using important drugs such as insulin or heart medication.

These user fees place the blame for costs of the drug program on the poor and on seniors. It's like a new tax on the poor and on seniors. User fees are not cost-cutting measures; they are new revenue sources that hit the poorest of society the hardest.

Deregulation of drug prices: If this government deregulates drug prices, it would be the only province in Canada to do so. The price of drugs will surely increase, particularly in remote or small, rural communities. It will have an impact on our members' benefits packages, because it will increase the cost of supplementary health insurance benefits. But on top of that, nearly 2.5 million people in Ontario have no insurance to cover drugs. Clearly there will be a huge impact on them. These changes will also hurt seniors and low-income families and individuals, including the working poor. Prescription drugs must be affordable to all.

1120

In conclusion, I remember that in the mid-1980s this country debated whether to be part of the Canada-US free trade agreement. Overwhelming concerns were raised about the necessity to protect our social programs and health care system. Canadians were assured that our social programs were not for sale, that they were part of Canada's sacred trust. Yet less than a decade later, we find ourselves before this committee responding to Bill 26, an anti-democratic piece of legislation which seeks to dismantle medicare eroding the universal, accessible health care system upon which Ontarians rely.

Bill 26 will change for the worse our communities, our public institutions and the care ensured the elderly, the sick and the poor, without public debate or accountability.

If this government believes there are problems in our current health care system, it should consult with those

who work as health care providers and administrators and with communities and individuals served by them.

If this government wants to start altering what is probably considered our most cherished social program, it must do so only after commencing broad consultations with the people of this province. If it had done so before setting out its hidden agenda in Bill 26, for sure it would've learned that the people of this province will not stand for the dismantling of our medicare system.

We call on the government to withdraw Bill 26 and for this committee to make that recommendation.

We welcome any questions.

Ms Lankin: Thank you for your presentation. I don't have questions so much as a couple of comments. I sat through hearings all through northern and eastern Ontario last week on the health sections of the bill, and I heard the government members say over and over again to groups such as yours: "We're listening. We're out here because we want to hear from you, and we're listening."

Then I come here today and I see this crap out on a table that says, "Ten Great Things About Bill 26 That You Won't Hear From The Vested Interests." You're here today and these people are listening to you, but in their minds you're a vested interest, the people who are out here watching this are vested interests, and they don't want to hear from you or listen to what you have to say.

They also put out a whole bunch of things they call myths, and it addresses the democracy you talked about. For example, they say it's a myth that the government tried to sneak Bill 26 into the House without any debate. Let me tell you, I, as the Finance critic, and our leader and the Liberal Finance critic and their leader and many other opposition members were locked up in the pre-economic statement lockup when they brought this bill in, unprecedented.

They say that as an omnibus bill it's not unprecedented, that there have been many more. There has never been an omnibus bill that dealt with policy issues like this. It has always been housekeeping. Their comparison to NDP legislation is pure misleading of the public in a way that is certainly not credible, but is not worthy of anyone attempting to govern the province of Ontario.

They say, "Myth: The PCs tried to ram this bill through with no debate or public input." They call that a myth. Here we are, one week before we go into clause-by-clause, and we haven't seen the amendments from these people. No one's going to have any public input on what they're proposing in amendments. I imagine we'll get them at the last minute, like we got the bill, and be expected to deal with it, understand it, vote on it and they'll ram it through. They'll do whatever they want.

This is a fundamental denial of democracy in this province. Your brief has hit it right on. The people here have made it very clear that they want to have a say. We have two motions coming up, one urging this committee to recommend that we come back to Windsor, the other urging that the amendments get tabled. I hope the government members will listen to what they've heard here today and to you and will support those motions.

Mrs Ecker: Thank you very much for your presentation. I'm sure if we were to bring in amendments before we had heard from all the many people coming forward

with very useful suggestions, the opposition would quite rightly come down on us for not listening to the rest of the presentations.

As an organization with a lot of experience and expertise in negotiating good health packages, insurance packages, drug and dental service packages for your members, in many cases excellent packages above and beyond what some people have access to in the public system, one of the issues in financing those kinds of insurance plans, I understand, is cost control, difficulties with increasing costs. We've heard from some people who have come before us that, for example, with seniors there have been serious problems with the overprescribing of drugs they don't need. One figure was something like 30%; the seniors groups were telling us that. One of the other presenters earlier today talked about the need for a smart card so we could, in their words, better track patients' or clients' use of the system.

The statistics indicate that in one particular month we had, for example, 7,000 individuals who went to see five or more family physicians in one month, which I think most people would see as pretty serious. So if—just a second—

Ms Nash: If I can address the overprescribing—

Mrs Ecker: Excuse me. Just let me put the question. Based on your expertise, how do we go after those kinds of concerns in the system without some access to information, with appropriate confidentiality protections? How do we do that without some sort of access to the information?

Ms Nash: Very simply, what you should do, before you bring in something heavy-handed like this legislation, is talk to the people concerned. For example, in the CAW we have a program of medication awareness that we have negotiated with some employers and brought in with many of our seniors' chapters. It starts off basically educating citizens about difficulties in using medication: about overmedication, about keeping old medication. It's a preventive way, it's non-intrusive, it's cost-effective, and it would work one hell of a lot better than giving American companies access to our confidential medical records.

Mrs Caplan: I want to congratulate you on an excellent brief, an articulate and a passionate one. I agree with your concerns and also hope that the government is listening, although I fear it is not. We have been demanding and requesting and cajoling and asking for this bill to be split to allow for public scrutiny so people can fully understand what this bill is doing. We've been asking for and demanding and requesting the amendments that they're going to bring forward. We had one press release from the minister almost immediately after the tabling of the bill and the start of these hearings suggesting that there would be an amendment on sunset of powers. We don't know what they have in mind, and I think it's tremendously unfair that people are coming here not knowing what the government intends. We see news reports with statements from Mr Clement suggesting that there will be substantial amendments, and I have requested repeatedly, during these hearings, that we have a chance to look at what they have in mind.

I want to assure Mrs Ecker that we would appreciate seeing those amendments as soon as you are proposing them. We would not criticize you for tabling them; in fact, we would thank you for allowing us to see what you have in mind, because that is due process and democracy. To suggest you're holding back on them because we might criticize you—we would only criticize the amendments if they didn't repair some of the damage in this bill. We would not criticize the tabling.

Second, again I would like to ask—this is a request, Mr Chairman—the government to let us know who produced this crap. Who paid for it? Who produced it? It is misleading, it misrepresents the reality of Bill 26, and in fact it is full of lies.

If it was produced by the provincial Progressive Conservative Party, the people of this province have a right to know; if it was produced by government, the people have a right to know; and if it was produced by your caucus people, we have a right to know who produced this. The only word for this, Mr Chairman, is crap, because it is full of lies and it is intended deliberately to mislead the people who are attending these hearings and coming forward with genuine concerns.

Mr Duncan: Mr Chair, your staff person was passing them around.

The Chair: Mr Duncan, Mrs Caplan has the floor.

Mrs Caplan: I yield to my colleague.

Mr Duncan: Who paid for that, Mr Carroll? One of your staff members was passing them out here. You ought to be ashamed of yourself. You're cutting back health care dollars and you're passing out Tory propaganda. Shame on you.

The Chair: Can I just correct the record? It was not one of my staff people handing out that brochure.

1130

Mr Duncan: One of your Tory caucus staff members. Let's clarify: one of the whiz kids. Who was it? Who paid for that?

Interjections.

The Chair: Thank you very much, ladies. We do appreciate your presentation today.

We now have two motions to deal with. The next group has withdrawn its presentation, so we do have two motions to deal with as put forward by Ms Lankin. Would you like to deal with those one at a time, Ms Lankin, please?

By the way, just for the information of the people on the committee, Ms Lankin had requested in Thunder Bay that the comments made by Dr Kotalik, a bioethicist we heard in Thunder Bay, be copied for the members of the committee. Hansard has done that for us and they are being circulated.

Ms Lankin: I appreciate that. Mr Chair, could you indicate the procedure for dealing with these two motions so we're all clear on time limits?

The Chair: Our standard procedure is that we've had five minutes' debate, one person per motion.

Mr Marchese: Five-minute debate and a few people can participate?

The Chair: One person is what it has been, okay?

Mr Clement: Oh, they can split it up any way they want.

The Chair: I'm just looking for all-party approval on this. I'll do it any way you want.

Mr Marchese: Five-minute debate.

Ms Lankin: Five minutes to be split up.

The Chair: Five minutes be split up per party?

Ms Lankin: Yes, and again, I reserve the right—

Interjections.

The Chair: I assume that all of you want to hear what Ms Lankin has to say. She has the floor.

Ms Lankin: That's a big assumption, Mr Chair. I just wanted to indicate that I will be splitting my time with Mr Marchese and I will be saving a short amount of time at the end to wrap up.

The first motion I am placing before the committee:

Whereas there has been overwhelming public interest in Bill 26 and that 42 groups and individuals have requested to appear before the standing committee on general government in Windsor, which far exceed the 15 spaces available today for hearings;

I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged for the community of Windsor;

Further, that this committee recommends that the three House leaders meet as soon as possible to discuss this issue.

Mr Chair, you know how strongly I feel about this. The opposition had to go to extraordinary lengths to get public hearings that would go out of Toronto in the month of January to give people time to develop their presentations, to understand the bill and to come forward in their home communities to be able to present the regional issues and regional concerns. So it wasn't just the Toronto-based process that would have happened had we proceeded with the government's intention to have it wrapped up before Christmas.

May I also say that at the time in which all three parties arrived at an agreement with respect to the schedule of hearings, none of us knew what the overwhelming public response would be or that the numbers of people and groups and individuals who have applied to appear would do so.

Mr Chair, you well know in these two weeks of committee time that the two committees are travelling, there are over 1,000 groups or individuals who have applied for less than 300 hearing spaces. If this government is truly listening, as it says it is, it would listen to the vast majority of presenters who have come forward and who have said: "Slow this process down a little bit. Let us have some more time for public debate. Listen to the people." That's what we have been hearing.

May I say that the opposition has made this offer before to the government and I repeat it today on behalf of the New Democratic caucus. We are prepared on January 29 to pass those few sections of the bill that you absolutely believe have to be done in order to meet your fiscal agenda crisis that you have set out. The vast majority of this bill deals with long-term policy changes which have immense implications for the province of Ontario and deserves to be under public scrutiny, to be

seen, to be known, to be understood and to be debated by the public before legislators come to the final decision-making with respect to these changes.

I urge the members of the government to listen to the words in the resolution, to understand that we will not be making the decision. We are simply urging the House leaders to meet to discuss this. They will make that decision. Please, listen to what you've heard from the presenters and please be part of this committee's recommendation to pass that information on to the government House leader so that we may have a proper debate about what democracy is in this province and how this bill should be handled and we might hopefully see a return to communities like Windsor so the public can have a full say about what they think this government should do with this bill.

The Chair: Mr Marchese, Ms Lankin didn't split her time evenly with you, so you have about 30 seconds.

Mr Marchese: Quickly, we have learned a great deal. We know that the interest is very great. We know that written submissions are inadequate because they enter into the world of oblivion. We know that one doctor in Peterborough said he could only understand a third of the document, meaning this document is completely incomprehensible even to those who are most literate. People need time, civic participation, in order to be able to influence. The direction of where this bill is going is critical, and therefore people need more time to be able to read and debate this bill.

Mr Clement: I regret that I cannot support this motion. The reasons are as follows. I believe the process is working very well, at least on the government side of the committee.

Interjections.

The Chair: Mr Clement has the floor. We allowed Ms Lankin to speak. Let's allow Mr Clement to speak too.

Mr Clement: I'd like to report to the committee that as a result of this process, by the end of this week, both sides of the standing committee will have heard, by my calculations, from close to 750 presenters, with a diversity of views. They are obviously not all favourable to the government, I concede that, and I actually welcome that. Although some people might not agree that I have that emotion, I welcome the criticism, I welcome the analysis, I welcome the ability of people to give us some very critical points of view and some very worthwhile suggestions, quite frankly.

Mr Marchese mentioned the rushed atmosphere that some of the presenters mentioned, but there have also been some very high-quality presentations. People have had the time to review the legislation, to come up with worthwhile recommendations, and I can at least say, from the government's side of this perspective, the recommendations are being taken very, very seriously and we want to improve the bill. Bills can always be improved, whether you look at them for five days or 500 days, and we can improve this one.

My final point would be this: Ms Lankin mentioned that she understands the fiscal exigencies the province faces, but there is also a health care situation that we face, a situation where, because of the way we spend the money, \$17.4 billion, we spend some money in areas

where it doesn't make sense: for administration, for heat and light, for hospital beds that don't have patients. And yet there are many other areas, and Windsor-Essex is a prime example, where there is need for more resources, for the mentally and physically handicapped, for palliative care, for long-term care. We want to fund those things too. But in order to do so, we have to make the changes that are necessary.

Interjections.

Mr Clement: We need to make the changes that are necessary, and I would say this: If we hold off even for one more month, that means \$720 million more going to interest on the debt rather than into the health care system, and I for one am not going to sit here and let that happen.

Mr Duncan: Absolute disgrace.

Mrs Caplan: That's a misrepresentation of what this bill does and you know it.

Ms Lankin: January 30, it's all over, is that what you're saying? No more deficit?

Interjections.

The Chair: Is this a combined presentation by the Liberals or does one of you want the floor?

Mrs Pupatello: I'd like to address especially Mr Clement's comments that he's just made. The reality is, and everyone in this room knows it, that we wouldn't be sitting here today if Alvin Curling, the Liberal member, hadn't sat in the House. As a matter of fact, if he hadn't sat that night in the House, where the rest of us joined him for the balance of the evening, we wouldn't have gone to any communities. We wouldn't have had the ministers themselves realize that amendments are required to this bill. We would have passed a bill in its entirety the way it was presented, and you and I both know that's totally inappropriate.

1140

Moreover, I want to tell you that in the limited time that we have had here, we have had the audacity of some groups come here who have just the day before been government spokespeople and now sit there actually speaking to government as if they are not some kind of vested interest. Today we've got another indication of that.

Why is it that this kind of propaganda doesn't have any indication of where it was printed? The Conservative Party didn't print this. You're \$5.5 million in debt, so it couldn't have been a party printing. Could it have been printed at Queen's Park? I think we need to know the answers to that. You've got the nerve to sit there and talk about public expense for public hearings, and you don't consider this a blatant waste of taxpayers' money and you don't have the nerve to put the fact that it was printed at Queen's Park on this.

I just want to tell you that anything we can come out with today is going to indicate further public hearings. We spent all day yesterday afternoon at the Fologar Furlan Club listening to more folks who didn't get on the list today. Every time we have a new group speak, we find something out about this bill that even the Conservative members don't know.

So I just want to tell you that, you, Mr Clement, and every other Conservative member who's here understands

the value of public input. Every new group that has spoken will elicit some other nuance of this bill that none of us realized in terms of its impact and potential impact on the communities, in particular in the area of health. You are in a community that has been devastated by this government. You have put off making decisions on the reconfiguration of hospitals for this area for months. You are changing all of the attitudes here for health. You're literally dismantling this before the bill is even passed.

This kind of action, as it stands now in Bill 26, will only serve further to destroy health in particular in Essex County. You've got command now, you are government. You have the power to allow us to have further public input, and we are asking you to consider further public input on this bill. Do not let this go through. All of the people of Essex county are asking that of you today.

Ms Lankin: Very quickly, Mr Chair, I have a list here of all of the groups who were denied standing before this committee. It includes groups like the Essex County Board of Education, Essex County District Health Council, the medical society, the Ontario Healing Arts Radiation Protection Commission, Windsor and District Chamber of Commerce, the Windsor Area Action Group, the Windsor academy of radiologists, the Windsor and district council of CUPE, Windsor Women's Centre, on and on and on.

Mr Chair, in addition to this, there are all those groups who didn't get their application in in time because the ads were in the newspaper over the Christmas holidays who haven't had a chance to come forward. There are many people here who approached me this morning and said they would like to be on but they just found out about it as the hearings last week started on the other half of the bill.

I say again to the members opposite, if you are truly listening to what people have said, you will understand that there are portions of this bill that will fundamentally change the value of our health care system in this province, the values that underscore the Canadian medicare system that so many people fought for so many years to build, and you will allow public debate to determine if that in fact is the way the people of this province want this new government to take us.

Don't be afraid of debate. Don't be afraid of what the public has to say. Take the time to listen. You will only end up with better legislation as the result of that.

Recorded vote.

The Chair: Ms Lankin has asked for a record vote. Just to explain to the audience, there are only two members here, the way the committee is structured by the Legislature, Ms Lankin and Mrs Caplan who have a vote; three members on this side.

Ayes

Caplan, Lankin.

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated.

Ms Lankin, your second motion.

Ms Lankin: Thank you, Mr Chair. In light of the fact that again the government members refuse to pass on to

the government House leader the need for further hearings on this, and in light of the fact that this means it is clearly their intent to proceed with the bill as is scheduled for passage on January 29, my second motion reads as follows:

Whereas there are only five days remaining for public scrutiny on Bill 26; and

Whereas the public interest in this bill has been overwhelming; and

Whereas the vast majority of presenters to the standing committee on general government have recommended major changes be made to the bill;

I move that this committee recommend to the government House leader that the 95 individuals and groups that requested to appear before the standing committee on general government in Windsor be given the opportunity today to see the government amendments to Bill 26.

Mrs Caplan: You can't vote against that.

Ms Lankin: Mr Chair, Ms Ecker said earlier that if we were to table the amendments before we've listened to all of the public input we would be criticized for not having let the process unfold.

Ms Ecker, I know that you have been around legislative processes a long time and I know you know better than that in terms of the process that has always been followed by all governments, that where at all possible amendments are shared with the public and with members of opposition as soon as they are in a draft form so that we can give you input as to whether or not those amendments in fact address the concerns. It has always proceeded that way because governments have the resources of large legal departments and bureaucratic departments of advice to help those amendments be drafted, and opposition parties, as you know, have research staff in small numbers and rely on legislative counsel who are very overworked this week, trying to put together potential amendments. It is always the procedure that government shares those amendments so that the opposition knows whether any areas have been taken care of and what further areas or refinements to their amendments may need to be done.

On Monday, when we start this process and we must file those amendments, we have no further time to deal with this, other than trying in committee to deal with amendments. Both committees are going to be put back together in one room to deal with this whole bill and all the amendments over the course of one week. We will be scrambling, trying to deal with the amount of them. It is absolutely imperative that you provide us with this information.

Last week I heard over and over again the three of you saying: "We're listening. We want to continue to listen next week and then we'll develop our recommendations."

Interjection: They're not even listening now. Look at them.

Ms Lankin: You know something? I almost was sympathetic to that until I found out from a very, very reliable source inside government that your government dealt with a package of amendments at the policy and priorities board of cabinet early last week. You've already got them passed and approved and you're not sharing them with anyone. This is intolerable. You will

repeat next week in clause-by-clause what you attempted to do before Christmas in terms of ramming this through without proper examination, without proper comment and without proper due process. I implore you to support this motion.

The Chair: Ms Lankin's giving you a lot of practice at 30-second statements, Mr Marchese.

Mr Marchese: It's all I need, Mr Chair. Just two comments. The first one is that enough presenters have presented, on the whole, many common amendments that we have a sense of the kinds of amendments that the government members can bring forward.

Secondly, it's important to get the amendments they have in mind so that we have a good sense of what they're listening to and what direction they're going into. Without that, we will not know what they're listening to as the deputants make their presentations.

We would be very helpful to them, it seems to me, in terms of making suggestions to the amendments they're making, so that once they're presented there will be greater agreement among all parties if they did that. If they don't do that, it'll be a problem. So we urge them to give those amendments now so we have a sense of what they're listening to and what direction they're going into.

The Chair: Thank you, Mr Marchese. Mr Clement.

Mr Clement: Again, I thank Ms Lankin for the motion. I'm with you about 95% of your motion, so I'd like to discuss at the end the problematic part.

With respect to the policy and priorities committee of cabinet, as the member well knows, they very rarely deal with precise wording of amendments. So it is not accurate to say that there is precise wording, but there are amendments being considered by the government. I will confirm that for the public. There's nothing to hide here. We are looking at potential amendments.

Mrs Caplan: If there's nothing to hide, table the amendments.

Mr Clement: From my perspective, may I say that Mrs Ecker, Ms Johns and myself are very sympathetic to the argument that these should be presented as soon as humanly possible, because they should be part of the discussions as soon as we can do that. So I don't disagree in theory with your motion.

1150

Mrs Papatello: That doesn't do a thing for us, Tony.

Mr Clement: I think what we have to do is, right now we're just starting the process of amendments internally so that we have a comfort level as committee members with that process as well. I think I can make a verbal commitment that as soon as they're in a draft form that we can share with this committee, we will share them, believe me, with this committee.

The only word in Ms Lankin's motion—I haven't conferred extensively with my colleagues—the only thing I think theoretically that causes us problems is when she says "be given the opportunity today." We can't do it today. If you wish to amend your motion, Ms Lankin, to say "as soon as possible," you have my vote on this motion.

Interjections.

Mr Clement: Can I ask Ms Lankin whether she's going to amend her document to that extent? It's a

friendly amendment but I'd like to ask in good faith for a response.

Ms Lankin: I can assure you that if you defeat this motion today, I'll give you another opportunity tomorrow to pass it.

Mr Clement: Fair enough.

The Chair: Are you finished, Mr Clement?

Mr Clement: Did you have something to say, Mrs Ecker?

The Chair: Quickly.

Mrs Ecker: I'd just like to say that Ms Lankin has pointed out that I have been involved in previous legislative procedures, and I have. I have received big chunks of amendments on a Friday night that we had to respond to by Monday morning, and didn't like it then. That's why the minister has given the commitment that we will be releasing amendments as soon as we can possibly do that. But we also want to make sure that we don't miss the good points that are being brought forward by many of the groups that are here, which you yourselves have said are good points. We want to make sure we do them right.

Mr Crozier: To respond to a couple of things, certainly with this motion the real intent behind it is, I believe, that we should be able to get to the amendments and we should be able to understand the government's direction as quickly as possible.

Again, the excuse has been given that the government doesn't want to put any amendments forward because they don't want to miss some of the good presenters. Well, quite frankly, it's not unusual for amendments to be tabled at the beginning of hearings on a bill. It's not unusual for amendments to be tabled partway through, and then if there are other presenters who, let's say, give another opinion, then you can amend those amendments.

Mrs Caplan: Or withdraw them.

Mr Crozier: Or withdraw them. Thank you. To say the process has to wait until everyone's been heard from I think is untrue and unfair. Maybe it's not untrue, but it's unfair.

I'd be willing to bet, fellow committee members and ladies and gentlemen, that these amendments will not be tabled until the very last minute. I am in fact willing to stick my neck out far enough to suggest that there won't be significant time to review these amendments. But I don't think there'll be any meat to a lot of these amendments. I think there will be a great number of them. In fact, we have a pool going—and we invite the government to join it—as to how many amendments there will be.

Mrs Ecker: I'll take a bet.

Mr Crozier: So I suggest there will be lots of amendments, but it's the quality of the amendments that really counts, not just the number. I don't want anyone to be smokescreened by the fact that there will be a great number of them. In fact, I suggest that this legislation is so poorly written that the legal department has been scrambling to correct and to bring forward amendments in just the way it's been drafted, notwithstanding what anybody has said before this committee.

We had a bill just before the House broke in December that was two pages long, had eight sections, and the government tabled six amendments. If you translate that

into a bill of 211 pages long—I suggested at that time that some of the legal staff that's advising and drafting these bills would have a little difficulty with a two-car funeral, I suspect.

So I think you're going to have to consider the real context of these amendments and the fact that there is going to be very limited time. I suggest that with the number of amendments that will come forward there won't even be enough time to discuss each one of them and that they then will be simply accepted as tabled.

Mrs Caplan: That's not democratic.

Mr Crozier: Mrs Caplan says that's not democratic, and I agree—but we've heard from many, many presenters who have said the whole process is undemocratic—partly because, and I think it's misleading to some extent, this information says: "Well, we offered 360 hours of hearings. The opposition didn't like that. We only took 300." They offered 360 hours. It was going to be in Toronto. It was going to be before Christmas. You were going to go through till midnight. We've heard from disabled people in Windsor and London and Kitchener and Niagara Falls and in the north who wouldn't have been able to get to Toronto. So the point is, the whole process would have been very undemocratic had we not taken the steps that we did.

I would also ask the government to please understand what people are asking for. They only want to know where you're going, what direction you're going to take, are you listening, and they just want to know this ahead of time. So please table those amendments.

The Chair: Ms Lankin, a final sum-up.

Ms Lankin: Again, I'll try to be very brief, Mr Chair. May I say to Mr Clement that I appreciate his sentiments of support for the intent of the motion. The reason that I don't find it satisfactory to amend this motion to simply say "as soon as possible" is because I got a clearer commitment than that from the minister.

On the very first day of hearings in Toronto, on December 18, I put the question to the minister, would he commit to this committee that we would receive copies of the amendments that he was proposing, because he'd already talked about one that first day, prior to going out on the road on public hearings so that the public knew what areas the government was intending to amend? They could comment on the nature of those amendments, whether they were satisfactory, and if they resolved the concern, we didn't have to keep talking about that issue and we could concentrate on other issues.

I quote to you Health minister Jim Wilson's own words: "We have no interest in holding amendments back. I found that frustrating when I was in opposition actually and I couldn't understand why the government, when a good point was made and agreed upon, would wait till the last day to put in amendments and continue to get hammered day after day, witness after witness, when they're already intending on doing it."

I point out to you that you are continuing to get hammered day after day, witness after witness. We know there are areas where you are going to make amendments. Share them with us. Let us decide collectively with the public whether you've addressed concerns. Be, as a

government, facilitative of the process in terms of producing the best legislation, not a barrier to it.

So I stand by the motion that I put forward and I do indicate to you that I will repeat this motion every day, because I believe this committee should be making a firm statement to the government House leader that the government has been mishandling how this bill has been proceeding.

The Chair: It's now time for the vote.

Ms Lankin: Recorded vote.

Ayes

Caplan, Lankin.

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated.

Just a couple of things before we break for lunch. I do want to compliment the audience and thank them for allowing us to hear the presentations. We do appreciate the fact that you don't always agree but we do appreciate your attention in allowing us to get the presentations done. We recess until 1 o'clock.

The committee recessed from 1159 to 1300.

CANADIAN MENTAL HEALTH ASSOCIATION, WINDSOR-ESSEX COUNTY BRANCH

The Chair: Good afternoon, ladies and gentlemen. Our first group this afternoon is the Canadian Mental Health Association for Windsor-Essex, represented by Pamela Hines, executive director, and Thom Morris, who's a volunteer. Good afternoon and welcome to our committee. You have a half-hour to use as you see fit. Questions, should you leave time for them, would begin with the Liberals, and the time would be shared evenly. The floor is yours.

Mrs Pamela Hines: On behalf of the Canadian Mental Health Association, Windsor-Essex County Branch, I want to thank you for the opportunity to present some of our views regarding Bill 26 for your consideration.

Canadian Mental Health Association, Windsor-Essex County Branch, is an incorporated, registered, non-profit charitable organization locally established in 1971. This year we are pleased to be celebrating our 25th anniversary in providing mental health services in this community. We are one of 36 branches in Ontario having membership with our provincial and national associations.

The Windsor-Essex county branch has approximately 240 active volunteers that provide direct program support as well as board and committee services. The branch has a rich history of providing mental health services in this community through education, prevention, advocacy and support services. The programs and services provided by the Windsor-Essex branch are funded by government grants, the United Way and supplemental fund-raising activities.

The Windsor-Essex branch has supported the efforts of the Canadian Mental Health Association, Ontario Division, in recommending deficit reductions as a target for the government during pre-budget submissions over the

past several years. We acknowledge that major changes are required in the health care system. It is essential that we create a cost-effective system which makes the best use of our resources to meet the needs of individuals coping with mental illness and their families. To that end, the Windsor-Essex county branch has been working in cooperation with the local district health council, community partners, consumers and families to plan and implement creative options to cope with the economic environment and improve services.

Our comments to the committee in response to Bill 26 will be limited to the potential impact on consumers in the mental health system with a view to identifying possible changes that will limit the risk of implementing measures that could be counterproductive to a fiscal plan which is balanced with providing responsible mental health services.

It has been documented in reports by all three political parties in the last decade that there is an urgent need to restructure our mental health system to shift from a dependence on hospital beds to a community-based model. The community system has been characterized as underfunded and fragmented. Funding is centred on provincial hospitals and psychiatric units rather than community services. We believe it is essential that cuts to the mental health system are not made solely for the purpose of short-term gains but rather in the context of an integrated approach, such as the excellent strategic plan outlined in the government document *Putting People First*.

Extensive local planning has been conducted to implement principles of mental health reform consistent with the government's fiscal plan. The Windsor-Essex system reconfiguration is recommending that psychiatric beds be reduced from 115 to 90. The London and St Thomas Provincial Psychiatric Hospital amalgamation proposes the closure of one site and the possible reduction of 240 beds. Historically, bed reductions have seldom been offset by strengthening community services. We encourage the government to support the recommendation of the Provincial Psychiatric Hospital Restructuring Committee that no downsizing of beds occurs until such time as the local communities have a plan and the resources to provide appropriate supports and services to this population.

Local mental health services are underfunded and overburdened with demands for services that cannot be met because of prior deinstitutionalization and increasingly limited access to hospital services that are streamlining and narrowing their mandate to accommodate budget reductions.

The Windsor-Essex mental health community is unanimous in supporting the recommendation of the Provincial Psychiatric Hospital Restructuring Committee to explore a decentralized option of the transfer of specialized beds and services to communities such as Windsor. With the planned closure of acute-care beds in Windsor we have the capacity to accommodate these services, and it is opportune to incorporate such a move in our local planning process. We are prepared to take responsibility for providing these supports in our com-

munity and believe it would be cost-efficient and significantly improve access, availability and quality of service.

We recognize that there will be no new dollars. However, it is essential that dollars be reallocated in the mental health system. The retention of any saving from the restructuring and downsizing of psychiatric beds to fund the government deficit or to finance a tax break would further erode essential services for individuals coping with psychiatric disabilities, putting vulnerable people at risk with inadequate and/or no supports. This could prove contradictory to the government's fiscal agenda if more costly and inappropriate services such as the justice system are accessed as an alternative.

Reallocation of dollars alone will not improve services. How those dollars are spent will be vital in determining a positive outcome. Resources must be designated to strengthen community organizational processes. We need support and the tools for organizational development activities, such as human resources, volunteer programs, strategic planning, financial management, information and communication technology, as well as research that will assist us in determining the program models for the best outcomes for consumers.

Bill 26 extends considerable ministerial powers and authority. While we recognize that decisions must be made to effect changes, we are concerned about the process. We believe that health services are strengthened when stakeholders are involved in the planning and design. We can benefit from the knowledge and expertise of professionals, volunteers and those for whom the services are intended, to provide creative solutions. We believe the mechanism for full consultation is already in place under the auspices of the local district health councils which make recommendations to the government. Following consultation, we recognize priorities must be determined, but this should not occur without the benefit of full participation.

The mandate of the Health Services Restructuring Commission is vague but appears to be specific to hospital restructuring. We believe that hospital restructuring will only be implemented successfully if considered within the context of the planning and enhancement of community services. We encourage the government to examine the process of the Windsor-Essex reconfiguration, which shifted from a hospital to a health system model.

Each community has its unique concerns, and what works in Toronto may not be appropriate for other jurisdictions. We suggest that the government focus on the conceptual model and criteria to help mental health evolve and establish a decentralized governance system in which local communities determine how best to meet the criteria in their jurisdictions.

Community organizations are dependent upon supplementary fund-raising to provide a broad range of services. Locally, the casino has already impacted on bingo revenue for many charitable organizations, increasing the competition for limited charitable dollars. Bill 26 will permit hospitals to establish crown foundations for fund-raising purposes. We are concerned that this will threaten the fund-raising efforts of the United Way and other community organizations already dependent on this

revenue. In the mental health system, this would be paradoxical to the shift from institutions to community services by further eroding acknowledged underfunded services.

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The Windsor-Essex branch recognizes the value of services contributed by volunteers, and we are pleased by the government emphasis on the usage of volunteers. The breadth of services provided by the branch is greatly expanded by our volunteers. Involving mental health consumers in a variety of volunteer activities has also provided meaningful activity for individuals to integrate in the community. These activities would be greatly enhanced if the government would support the utilization of volunteers by providing resources to recruit, train and support an effective volunteer program.

In the Health Insurance Act, schedule F, hospital privileges, Bill 26 requires new specialist physicians to be affiliated with a facility in order to obtain a billing number. This measure reinforces the affiliation of psychiatrists to the hospital system without providing any incentive to share their expertise with the community-based system which is the recommended future direction for mental health services. Many community-based services do not even have access to sessional fees for consultation services. To provide effective community mental health supports to reduce the dependence on beds, it is essential that community-based services have access to psychiatrists for program design, clinical direction, staff education, case conferences, planning and consultation.

Medical advancements in the development of psychotropic drugs in the 1960s made it possible to consider supporting individuals coping with mental illness to live in the community rather than asylums. Canadian Mental Health Association, Windsor-Essex County Branch, is concerned with the proposed changes to the Ontario drug benefit plan.

Medication is frequently a key factor in the recovery process and the ability to support mental health consumers successfully in the community. Medication complaints for some mental health consumers is already a challenge in establishing a consistent routine, particularly because of frequent unpleasant and adverse side-effects. The proposed changes would set up additional barriers that may reduce or preclude availability of necessary medication.

CMHA, Ontario Division, made a presentation to the committee in Toronto. We fully support its presentation and have attempted to focus ours on the local perspective. The issues regarding the changes to the drug plan are of such paramount concern to the Windsor-Essex branch that we will reiterate those points already made by Ontario division.

Many mental health consumers are prescribed several medications and some receive them on a weekly basis to diminish the potential for overdose. This means that a person with a psychiatric disorder who is on social assistance could, under the proposed changes to the Ontario drug benefit plan, be paying a \$2 dispensing fee once per week. This is a prohibitive amount for an individual on social assistance.

I'm going to skip some of these points for the economy of time, but they are in your report.

The mental health reform process has emphasized moving the psychiatric population into the community and assisting them to lead meaningful lives. Equitable access to the medications they require is part of sustaining a psychiatric consumer in the community. Our organization hopes and expects the government will make this possible, consistent with the principles in Putting People First.

The Windsor-Essex county branch offers a wide range of supports to individuals coping with a mental illness. These supports cannot be provided in isolation of availability and access to basic needs such as adequate housing, education, social supports, transportation and employment opportunities. Absence of these basic needs will severely limit the recovery process.

In summary, the Canadian Mental Health Association, Windsor-Essex County branch, acknowledges the need to reduce the public debt. We believe economic efficiencies can be achieved while improving services with a redistribution of dollars in the mental health system. We are prepared to continue to work collaboratively to achieve these goals in the process of mental health reform. Thank you.

Mr Crozier: Thank you, Mrs Hines, for your presentation. I would like to take you back to page 2 very briefly and ask for your comment about the third paragraph, where you say, "Historically, bed reductions have seldom been offset by strengthening community resources." Unfortunately, we've heard that this has been what has happened; there wasn't enough planning prior to moving to community-based care.

There has been this recommendation by the provincial Psychiatric Hospital Restructuring Committee not to do any downsizing until that's done. Can you comment on that, as well as, with your suggestion in the next paragraph, I suppose, if they are going to do downsizing and not plan for community-based, that you can use acute care beds that are closed in Windsor as an example. But do you still see moving away from any kind of institutionalization into community-based care?

Mrs Hines: There will always be a need for specialized hospital beds for psychiatric care. At this point in time, there is no cure for mental illnesses such as schizophrenia. It can be a very debilitating disease and the nature of the illness may require some individuals—not all—to occasionally be hospitalized for stabilization. But with the advent of medications that can help to reduce some of the symptoms of psychiatric illness, it is possible for longer periods of time and, in some cases with some individuals, to do it and provide supports without lengthy hospitalization.

Our suggestions at the provincial Psychiatric Hospital Restructuring Committee were that in amalgamating St Thomas and London Psychiatric hospitals, communities be provided enough time to plan for any repatriations of individuals who were formerly hospitalized to be given appropriate supports in their local communities. We would like to have the opportunity to make sure those community services and supports are in place before any further reductions in beds.

The decentralized option we're talking about here is that we would like to be able to provide even the specialized care in local communities where that's possible. Rather than Windsor residents who require the specialized services of a psychiatric hospital going to St Thomas or London for those supports, perhaps we could look at decentralized options; in other words, maybe 80 tertiary care beds in the Windsor-Essex area that are administered from the combined hospital of St Thomas and London, but in the local community. We possibly have the beds available here because of the restructuring locally.

Mr Marchese: Thank you for the presentation. I want to touch on a few things that you've mentioned and want your comment.

We have heard from a number of people who deal with a lot of different clients who are very vulnerable, generally speaking, on the effects the user fee would have under the drug benefit plan. Some people talk about the \$2 fee, the general fee, and for those who make over \$16,000 you'd have a \$100 deductible and the dispensing fee.

But what some others forget is that as this government gives municipalities and others more tools, there will be more user fees. Municipalities will impose them, hospitals will impose them, doctors will impose them, and independent health facilities will also impose user fees. So when you add the accumulated effect of those fees, it will have, I would think, a devastating effect on the consumers you deal with on a regular basis. Is that not the case?

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Mrs Hines: One of the points that I made later on in the presentation was that people who are mental health consumers also need access to public transportation and adequate housing, and there are concerns that if things like subsidized bus passes and the subsidies to the rest homes, those kinds of basic needs, are also attached with user fees, it may become very difficult to support individuals with mental health problems in the community.

On the drug issue, I'd just like to point out that \$2 does not sound like a lot of money, but many of our consumers may be on five to maybe 15 different prescriptions to deal with different side effects and the nature of their illness. So you're not just talking about the dispensing fee for one prescription every three months; it's a cumulative effect.

Mr Marchese: I agree. Part of the fundamental flaw, in my view, is that the user fee assigns blame to those who have to get prescriptions, and it almost assumes affordability. Both of those two assumptions, in my view, are false. It communicates a sense that seniors who need drugs, for example, are the ones to blame for having to get that prescription. I think that's not so, and a number of people have shown that. Do you have an opinion on that as well?

Mrs Hines: I think the important thing in terms of drugs or any other user fees—one of the suggestions has been that individuals on social assistance can go out and find additional employment to make up the difference. With our population, because of the nature of their illness, sustaining ongoing employment in the community is very difficult. Again, that's another area where perhaps in terms of supports we need additional supports to help

in terms of job readiness and the supports they need to maintain even minimal employment hours.

Mr Marchese: As I read Bill 26, or at least parts of it, and hearing a number of deputations, I see nothing in this report and this bill that helps community services or helps to strengthen community based health services. So I'm not sure that I would have any hope that this government necessarily, through this at least, will hear you.

You pointed out on page 4 a problem: "In the Health Insurance Act, schedule F, hospital privileges, Bill 26 requires new specialist physicians to be affiliated with a facility in order to obtain a billing number. This measure reinforces the affiliation of psychiatrists to the hospital system without providing any incentives to share their expertise with the community based system." That's yet another example, in my view, if anything, that what's contained in this does not support what you're after but rather weakens the kinds of things that you would like to see this government doing. Is there anything in this bill that you see might be helpful to you?

Mrs Hines: I think that what is happening in terms of hospital restructuring right now is that if there is consideration that the money be redirected as opposed to put towards the deficit, this could be a mechanism for shifting to a community based system. My understanding is, and my hope and expectation is, that the community investment fund will be confirmed and implemented by this government. But these are the issues that we would like consideration given to in regard to mental health.

Mrs Johns: Thank you very much for your presentation. I appreciate it. I would like to just confirm, to go forward from where Mr Marchese finished off, that the government has been showing that it will be investing in community services. We've been investing in dialysis machines, we've been bringing back a number of our Ontario residents who have been in the States as a result of a prior brain injury, we're doing measles immunizations. I know that's only the start, but that is a reallocation of dollars within the health care system and into the community.

I'd like to thank you for recognizing the need for change in the system. I think we all want change to make the health care system better for all of us.

In the previous government, what happened was that they had to delist some drugs off the formulary twice. I think they delisted 130 different drugs the first time, which resulted in \$20 million in savings, and the second time I think it was 110 drugs, resulting in \$37 million in savings.

To me, delisting drugs off the formulary is a 100% user fee, if you will, because the person then has to pay for it totally themselves. It was our government's vision that this isn't the way we wanted to go with that, that we were looking for some alternative to be able to keep as many drugs on as people needed and at the same time allow for new drugs to come on because there's such change in drugs, as you know, in mental health and in AIDS and a number of different areas.

Are there any other recommendations you would have if the copayment won't work in your area? You obviously—well, maybe—don't like the delisting either?

Mr Thom Morris: One of the key components is looking at populations that are at risk and that had been identified that are at risk and look at some generic envelope funding perhaps to help address those types of population; rather than look at a generic or universal system, look at some partitioning for some populations that are at risk with some specialized funding mechanisms to assist them in ensuring that they can remain out in the community rather than ending up in a costly hospital bed.

Mrs Johns: I heard you suggesting that to downsize the beds in the institutions, we had to make sure that the community was ready to accept these people and had the funds to be able to do that. You then proceeded forward with suggesting that the district health council was probably the best person in the community to decide how to proceed with that. Was that part of the district health council's plan in the restructuring of the hospitals, or would this have to be a separate plan for the district health council of Windsor and Essex county?

Mrs Hines: The local district health council has a mental health committee and certainly has done a great deal of planning locally with respect to mental health reform and working in cooperation with the proposed downsizing of the psychiatric hospital. What I'm suggesting is that we already have that mechanism in place for consultation. We recognize that just as this committee is consulting right now, you will not be in a position to implement every single recommendation that everybody gives. Decisions have to be taken. What we're suggesting in terms of the process is that the consultation, when you've already got the mechanism in place, is very key to the success of the process.

The Chair: Thank you. We appreciate your presentation and your interest in our committee process.

WINDSOR AND DISTRICT LABOUR COUNCIL

The Chair: Our next presenters are from the Windsor and District Labour Council, represented by Gary Parent and Nick LaPosta. Good afternoon, gentlemen.

Mr Gary Parent: Thank you, Mr Chairman. I'm the president of the Windsor and District Labour Council. To my right is Nick LaPosta, secretary-treasurer of the Windsor and District Labour Council.

Before I get into my brief, I want to say how disappointed I was that obviously there was a group that did not show up, the Silent Majority. I think, Mr Chairman, that you can be well advised that you are hearing at these hearings from the silent majority, that being us. I believe you used that time. Even though it was entertaining to see the debate as it related to the motion, I think it would have been better spent if you'd had the additional representation made by one of those groups that could not have made representation.

I also want to make a comment if I may before I start pertaining to something that was said today, and that's from the Hôtel-Dieu Grace board as it relates to the proposal on provincial government funding being directed from the centre. I guess I have some problems with that theory in having the real faith that that money was going to be spent in the communities that do need it and how

it would be determined which community would get it. I say that because we have before the government today a proposal. And as we have heard testimony here today—I would hope that the members are well versed with the Win-Win scenario that took place in this particular community, and we have put forward to your government proposed savings of the amalgamation that your government is sitting on, holding this community hostage as it relates to better health care reconfiguration that this whole community sat in.

Mrs Ecker asked this morning, "What makes this community so great?" Just let me say, Mrs Ecker, it's consultation. Your government refuses to consult with the people of Ontario, and I'm saying to you that if you want a better health care system, then extend these hearings so that you can consult with more people.

We have before us the omnibus bill that we dealt with last week as it relates to the general items and when we're dealing today on the whole question of health care, I can say, Mr Chairman, and to the committee as a whole that I think you are fortunate. You have the expertise of two ex-Health ministers sitting with you to probably and hopefully give you advice that you will adhere to. They have gone through it, they have experienced what your government now is going through. Listen to them, listen to the people of Ontario and don't listen to a circle of whiz kids who are dealing and going through your government and putting forward in this government some ideological differences that we feel are going to be detrimental to the people of Ontario.

First of all, we want to say that we are expressing our profound opposition to the content of the omnibus bill and in particular, the sections pertaining to health care and also to the undemocratic process with which it's being foisted upon the citizens of Ontario.

It repeals existing law giving preference to Canadian-owned, non-profit health; it deregulates drug prices and introduces user fees and deductibles for seniors and social assistance recipients, two of the most vulnerable sectors of our society.

If you want to really talk about the silent majority, I suggest you, as members of this government, talk to the constituencies of the poor, the seniors and the elderly and the sick in your particular respective constituencies to see if you're travelling down the right path.

It grants government, this Tory government, enormous arbitrary power over doctors and strips away the negotiating rights and agreement of the Ontario Medical Association. This bill, in our opinion and in fact the opinion of many other Windsor residents, is a clear indication that this government favours the American for-profit style of health care. Well, we in Windsor-Essex county want to state loud and clear to this committee that we want no part of for-profit health care, as our health care is not for sale in Windsor-Essex county or the province of Ontario.

I want to say that here in this community, and this has been—and contrary to what, and I've had this argument and discussion before with some of my colleagues—God bless Tommy Douglas—but the health care system in this province started right here in Windsor, Ontario, with Windsor Medical. It was the first prepaid medical in the province of Ontario and in fact, in Canada and I just

want to say that when you attack the health care system, you are attacking a deep-rooted system we in Windsor-Essex county carry very near and dear to our hearts.

We are prepared to fight this government and any other government every step of the way to make sure it doesn't happen now or in the future. The government committee members might say that these are very harsh words and that this is not what the proposals in Bill 26 really mean. Well, let's just examine what we have found to be included in the bill and maybe you will see why we, and many others, feel the same way. I'll ask Nick to continue on with the presentation.

Mr Nick LaPosta: Thank you, Gary. Bill 26, as it amends the Ministry of Health Act: The first thing that makes us suspicious is what we find in the new section 8 of the act. There is no reference to district health councils and, if they are still to be left in existence, what exactly their relationship would be with the newly established Health Services Restructuring Commission which, as we interpret, has no restrictions on its duties.

Even though we in the labour community have not always had a good relationship with the Essex County District Health Council, we are of the strong belief that there should be a cross-section of the community represented on a body, such as the district health council, to make sure the citizens of Windsor and Essex county have the best health care services available, as Bill 26 amends the Public Hospitals Act. In Bill 26, sections 5 and 6 have been repealed and replaced with clauses giving the minister discretion over when, how much and under what conditions the minister will give grants, loans and/or financial assistance. He also has the power to require repayment and to reduce or terminate grants and loans. His only criteria are that he must consider the public interest. This new section 6 also gives the minister the power to close hospitals, order hospital amalgamation and specify the services to be delivered by a hospital if the minister deems it—deems it, mind you—to be in the public interest.

Under their definition of "public interest" is a phrase stating "availability of financial resources for the management of the health care system and for the delivery of the health care system," which is then, in our opinion, when the Minister of Health may well decide to make less resources available for health care because more is needed to cut the income taxes of the well-to-do.

Amendments to the Private Hospitals Act: In schedule F of the act, it is amended to give the minister the power to revoke a private hospital licence at any time and to reduce or terminate any grant, loan or other financial assistance without notice where the minister considers it in the public interest. No hearing or rights to appeal presently provided under the Private Hospitals Act would apply.

Amendments to the Independent Health Facilities Act: Under the current act, services covered by the act can only be provided in licensed health facilities. Generally speaking, these services presently covered by the act include various diagnostic, surgical and other services provided in outpatient clinics for which facility fees are paid by the Ministry of Health.

The proposed changes to sections of this act, which repeal all preference for the non-profit or Canadian, in our opinion, challenge our ability to maintain a universal, accessible, not-for-profit, publicly administered health care system in Ontario. The minister can under Bill 26 direct that a request for proposals be limited to one or more specified persons. This raises to us the real possibility that for-profit US health care providers will be licensed to provide health services in Ontario. As we all know, American corporations are extremely interested in our health care system. They call it the "unopened oyster," and care for the elderly is referred to as "mining grey gold." The proposed changes allow the Minister of Health to handpick corporations or individuals who will be able to open up businesses and franchises of health care clinics that charge people money.

We are also very concerned that Bill 26 gives the minister the power to collect and disclose patient information for the purposes of administration of the Independent Health Facilities Act, the Health Insurance Act or the Health Care Accessibility Act and would encourage this committee to abandon these proposed changes.

Amendments to the Ontario Drug Benefit Act, schedule G: The amendments of this bill introduce copayments and deductibles for the most vulnerable in our society, they being the sick and the elderly as well as those recipients forced on to our social assistance rolls. It also gives the cabinet the power to increase these user fees at any time, which in our opinion will not reduce the need for prescription medicine but will reduce the number of prescriptions that will be filled. Because of their limited incomes, they will have to make the choice between food, shelter or medicine. All of this, in our opinion, will increase the need for crisis intervention, hospitalizations, longer-term treatment and other social services.

We say to this committee in the strongest terms, examine what your government is doing, as user fees are not cost-cutting measures but rather new revenue sources which create more wealth for the drug companies at the expense of hitting the poor of our society in this province, which, by the way, will be the only province, we believe, that will not be regulating drug prices.

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Amendments to the Health Insurance Act and the Health Care Accessibility Act: In the amendments to the Health Insurance Act, we see the removal of the term "medically necessary," which means many services could be delisted. Differences could exist among the care provided by hospitals, independent health facilities and private hospitals. The government could easily differentiate on the basis of age, severity of illness and any other criteria the government determines in order to delist services.

You may say this will never happen, but when we look at subsection 11.2(4), which states that such service may be prescribed "only if they are provided to insured persons in prescribed age groups," which we interpret, as an example, could mean that no one over 70 receives a bypass or that a person with Alzheimer's will not be treated for pneumonia. The possibilities are unlimited, in our opinion, and what these changes suggest is the

slippery slope to the problem of what is sometimes called the burden of an aging population.

We feel with the ever-increasing pressure to cut costs and get patients out of hospital, government officials and health care providers could make value judgements based on age, which we believe to be totally unacceptable.

The amendments to the Health Care Accessibility Act provide cabinet with the specific authority to make regulations prescribing insured services for which hospitals would be entitled to charge an insured person.

While presently hospitals are charging patients for a limited range of insured services—for example, copayments for certain chronic care services—the bill will give explicit statutory authority for cabinet to make regulations which would permit hospitals to charge patients user fees for any hospital-based insured services, including those presently covered by OHIP. Examples of user fees would include accommodation and meals, necessary nursing services, laboratory and other tests, drugs, use of operating or obstetrical delivery room, and emergency room visits.

And if this isn't enough, the bill also authorizes an administrative fee of up to \$150 which hospitals may charge patients. This is completely unacceptable. The people in this province who are poor, who cannot pay the rent and feed themselves, certainly do not have \$150 if they are hospitalized, especially since living with a marginal income increases risks of illness and emergency situations.

Mr Parent: As we stated in the beginning, we would try to explain to this government and to this panel why we not only as a labour community but on behalf of every citizen, that silent majority in the Windsor-Essex area, especially on behalf of those who have not been allowed to express how they feel about this bill and how drastically they will affect our health care system in this province.

We see the amendments of this bill doing nothing more than Americanizing our health care system, which would absolutely not be in the best interests of the residents of the city of Windsor or the county of Essex or the province of Ontario. As we stated before, our health care is not for sale.

We ask this committee, as many others have asked and will be asking, to allow these hearings to be extended because of the complexity of the issues and the seriousness of the consequences that would occur as a result of the implementation of Bill 26.

If you care about yourself, your parents, your grandparents, your children and your grandchildren, you will agree with most of the people appearing before you that yes, these issues are very complex and that they do need more time to be examined to determine just how these proposed changes will affect the people of this province in the future in their daily lives.

I ask this committee, particularly the government members, to travel down our riverfront to the east along our beautiful waterfront. There is a park on our waterfront that is very appropriate that you should stop at. It's called Stop 26. You should go and visit it.

Mr Marchese: I have a comment and Frances Lankin has another question. Someone in Peterborough said—it

was a deputation of three people—that this act goes far beyond the traditional ideology of the Conservative Party. In fact many of us have observed that this party is no longer the party than many might have recognized. It is unrecognizable, and when you look at Bill 26, it does indeed alter the democratic process to an autocratic one. Both in terms of process and content we see a very radically different Conservative Party.

If you look at Bill 26, and you've enumerated many, it gives incredible powers to ministers, to cabinet, and it's a whole list of what can and can't be done, usually what cannot be done by someone else. Alterations to the tendering and licensing process, restrictions on relocation, minister's power to revoke licences or eliminate services, immunization from liability for licensing decisions, minister's authority to disclose health information, limitation on physician affiliation—there are pages and pages and pages of what powers they have and the limitations they impose on other deliverers of services around the whole issue of health.

In my view, it's incredible. This is why we have said people need time to review the document as you've done, because many people don't realize what's contained in Bill 26. There's a hell of a lot. So I'm supporting your call for further discussion on this matter.

Ms Lankin: I wanted to pick up on one of the points in your presentation, sort of expand it. You talk about services that can be provided to a group depending on their age. In the old act the reference to that which was there, which allowed things like breast cancer screening programs to women over age 55 to be established, or whatever, had a protection which said it had to be done in accordance with the Canada Health Act. It has been removed and there's now no protection in accordance with the Canada Health Act.

Mrs Ecker: That is not true.

Ms Lankin: Well, the section with respect to prescribing by age has been moved to another place in the legislation.

My concern is that what we see here is the ability to impose user fees, the ability to do things outside of the Canada Health Act that lead to a very different health care system. Labour has been in the forefront of the fight for our medicare system and the values reflected in that and what that means in terms of values in our communities. I just don't believe there has been a debate in the public that we should be moving away from that. I wonder if you could comment on that from a Windsor labour perspective. I'll just leave it open for you on that.

Mr Parent: I believe, obviously, that we would much rather be debating this in the open for many more months because we believe it deserves that attention. I can only share with you that I had the opportunity to speak to a group last week of mostly seniors. It happened to be at a Kiwanis club meeting and the discussion was around this whole bill. You cannot believe the amount of concern that is before those people as it relates to what is going to be taking place if this legislation goes through as it is.

I hear the government members, continuously all morning and again when you made a comment, on the whole question of that's not what it says. I guess what we need are those amendments you talked about earlier. If

they have some things that are going to clarify some of the things that have been put forward, those things should be tabled so they do become part of the public discussion and consultation process we're under right now.

I share your concern that being in the dark as you are, can you imagine what we would have been like if we had not had these hearings? It would have gone on if it were not for Alvin Curling and what he did. I can only say again that I wish he had a bigger bladder because maybe we could have got an additional few more weeks on the whole question.

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Mr Clement: Thank you for your commentary. I thank Ms Lankin for recognizing the point that the so-called age discrimination section was in the old legislation as well as the new legislation. She and I disagree on the impact of removing the Canada Health Act references. I argue that the Canada Health Act still supersedes. I guess she and I are going to have to argue that and hire lawyers or something.

I had a couple of particular questions about your brief, if I might, because some things you said jarred me and I went back to look at the bill and I just want to pursue it a little bit.

You say on the second page of your brief that the first thing that makes you suspicious is what you find in the new section 8. You say there's no reference to the district health councils. In fact, in the old section 8 there was no reference to the district health councils. The reference to the district health councils was in section 8.1, which is a separate section from section 8 and is not amended or repealed.

If you do have the opportunity to take a look at the old legislation, I encourage you to do that, but if my interpretation is correct, would that go some way to satisfying your concerns?

Mr Parent: No. The problem we have, whether it's 8.1 or 8, is that the linkage has to be made on the whole question of having district health councils be part so that there can be some community input into any decision-making as it relates to restructuring or the whole question of health care service delivery in this community. We see that as not being in this current bill.

Mr Clement: That's a fair point, but I did want to make it clear that the district health councils still exist in the new legislation.

You also say later on in your brief, with respect to amendments to the Health Insurance Act and the Health Care Accessibility Act, that we removed the term "medically necessary." I'm not sure what you're referring to when you say that, because I don't think we do that. Do you have an exact section that you're referring to?

Mr Parent: I don't have it in front of me, but I can certainly bring to your attention where it is and where it was removed. I will do that.

Mr Clement: That's fair. If I can take a guess, I think what you may be referring to is the definition of "insured services," which in the old legislation had a bunch of mumbo-jumbo which included "medically necessary" and in the new legislation—

Interruption.

Mr Clement: That's a legal term. In the new legislation it just says "'insured services' means services that are determined under section 11.2," so technically you're right. We have removed the term "medically necessary" services. But then if you refer to 11.2, it does reference medically necessary services. If that's the section you're worried about and, if my explanation is correct, does that go some way to alleviate your concerns?

Mr Parent: No, it doesn't, because again, if you look at 11.2, as we said, in the groups I believe—

Mr Clement: I know I'm putting you on the spot. I apologize.

Mr Parent: No. This is what consultation's all about.

Mr Clement: Page 92.

Mr Parent: It provides to "insured persons in prescribed age groups." That again leads us to believe the "medically necessary" part of it has been removed and you're isolating people in different age groups.

Mrs Ecker: It's right there. "The following services are insured services for the purposes of the act.... Prescribed medically necessary services rendered by physicians." It's very clear.

Mrs Caplan: Have you changed the definition of "medically necessary"?

Mrs Ecker: No, we haven't.

Interjections.

Mrs Ecker: It's the new act.

The Chair: Mrs Ecker, this is Mr Parent and Mr Clement having a conversation here.

Mrs Ecker: Sorry.

Mr Clement: I just wanted to raise those points just so we were all sort of rowing in the same direction and we understood what we were saying. I take it from your brief that you don't like the tax cuts. You think they're going to go to the rich. You don't want the tax cut at all.

Mr Parent: We have gone on record as stating that we feel the tax cut, as it has been allocated and has been stated by your government, is not going to be a fair tax cut across this province and it's at the expense of the poor.

Mr Clement: You acknowledge, though, that anyone who files an income tax form will get a tax cut.

Mr Parent: I guess I can say personally, from my point of view, keep my tax cut that you're going to give me and give it to the poor and the less advantaged in this province.

I don't think the people of Ontario elected this government to give this tax break to the more affluent, the ones that can afford it, because it's not going to be the \$16,000 wage earner or the one on social assistance that you've just cut. It's not going to be the ones under \$20,000 that are going to get a tax break. It's going to be the more affluent in this province.

Mrs Pupatello: I have a question for Nick. You and I were on a hospital board not too long ago and so we were personally seeing the kind of changes that were coming about in hospitals as a result of restructuring.

I wonder if you could comment on this: (a) that this government was elected on the promise of not cutting health care, but you and I have both seen what hospital administrations are now having to surrender to to try to effect cuts because the money is not there, even though

they were elected on no cuts to health care; and (b) because in our Win/Win for this area redistributing services to community base and perhaps not hospitals the labour community was more comfortable because even though there may be some shifts in labour from hospitals, you knew that the funding was being moved to community base you had some kind of sense of assuredness that people too would be moving but there would be jobs in community-based services.

This government has not kept its promise on moving to community-type services. Can you comment on the group you represent in that area?

Mr LaPosta: Thanks, Sandra. First of all, I want to tip my hat to a group that was here earlier and did make a presentation, and that's the Hôtel-Dieu Grace Hospital board. At least they came down here to make a presentation. Although I don't necessarily agree with everything they said, they were at least here, which is one step more than what the hospital board that I currently sit on is doing.

I personally believe the reason they're not here today is because they have yet to hear from this government what is happening with the moneys that they have requested through the reconfiguration and the downsizing of the two hospitals into it. They're afraid that if they were to make their voices heard in this committee here, out into the public, more damaging information would probably come down through the financial aspect of the dollars that they are waiting for. As we sit here, no official notice has yet been given to the hospital boards as to where they're at with the money that they requested.

Secondly, in reference to the reconfiguration process and helping our community to be prepared for the shift from hospitalization to community-based staying at home—to answer that question frankly, that's been going on for the past two and a half to three years anyway, and the community is not prepared to receive all those people who are already being cut and put back into the household, back out on to the streets.

The problem is that the more they keep requesting funds to get, for example, the district health council and all these service groups together to prepare themselves for this, there are people out there right now as we speak with no place to go, no health care and no system in place to catch them. That's the truth. That's what's actually happening.

Although we're sitting here and asking for more time, more hearing, more debate, it's because this government is asking us to take a leap of faith with them, the same leap of faith they asked us during the election. We all know what happened during the election. They haven't kept one promise that they said they were going to keep, such as no cuts in health care. That's the biggest promise that they are breaking to date.

The truth is we want these hearings out and into the open to discuss such things as Mr Clement brought up, for example, where there is a difference of opinion. But the difference of opinion should be for the betterment of all Ontarians and all Canadians, not just those who are looking for a handout from the government.

The Chair: Thank you very much, gentlemen. We appreciate your presentation.

ESSEX COUNTY DISTRICT HEALTH COUNCIL

The Chair: Our next group, the Essex County District Health Council, is represented by Jo-Anne Johnson, the chair of the implementation committee, and Hume Martin, the chief executive officer. Welcome.

Ms Jo-Anne Johnson: We're delighted to be here today, and I will start the comments by giving you some of the background and accomplishments of the district health council to date. The district health council was established exactly 20 years ago this month in 1976, so we're celebrating our 20th birthday this year. Our mission is to promote the development of an integrated health system through action-oriented health planning.

In the early 1990s, in conjunction with the Ministry of Health, we established a steering committee of local volunteers to develop a plan for hospital reconfiguration. Those volunteers consisted almost 50-50 of providers and consumers. The idea was spawned at the Essex County District Health Council but was quickly supported by the Essex County Medical Society, the hospitals, labour and other health professionals.

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We quickly found that hospital reconfiguration could not be developed in isolation from community agencies providing auxiliary health services, because it was presenting an incomplete picture.

In 1994, the health system reconfiguration plan was completed, the first comprehensive plan in Ontario. We have since then seen a reduction from five acute-care institutions in Essex county down to three through voluntary mergers. Reconstruction plans for two of these acute-care sites are completed and we are currently waiting for capital funding to proceed building. Two other sites are slated for closure. One will physically close and the other will be a consolidation point for all long-term-care beds. Savings will be realized with these closures two years from start of construction.

In 1995, with the Ministry of Health again, we embarked on a community study which will be completed in September 1996, producing plans for the reconfiguration of the community health sector, and we will then be ready to actually develop an integrated health system for Essex county.

We have begun development of linkages and working agreements between agencies, institutions and broader community partners. In 1995, for example, the district health council, in conjunction with the Windsor-Essex health unit, produced a joint, comprehensive health profile for Essex county, providing important data for our immediate planning purposes. I have brought a couple of copies of that report, if anybody would be interested in taking a look at it.

In 1996, the hospital unions in Essex county, six different unions, developed landmark agreements with the three existing hospitals and each other covering unprecedented transfer and seniority rights clauses. This contract is now a model for the entire province.

We have the pieces in place to develop an integrated health system. We have done this by taking the initial support of hospitals, medical people and health professionals and labour and we have broadened that support

to the general public by involving consumers in every DHC-sponsored committee, subcommittee and task force. We have involved the public through public consultation, fora, and through consumer-led, community-specific meetings to provide information to and gather from the public.

Our DHC can now boast that we have over 500 volunteers involved in DHC planning and educational activities. Out of this broad-based process, we have developed broad public support for an integrated health delivery system.

Essex county is ready to make change. We just need the capital dollars and continued government support to serve as a demonstration site for an integrated health delivery system, and I might add, in a strategically timely manner for the province's needs.

Mr Hume Martin: I'm the chief executive officer with the district health council. What I propose to do is to build on the presentation made to you in December by the Association of District Health Councils of Ontario and make four observations in terms of the impact of this legislation, as well as four recommendations in terms of things the committee might wish to consider.

The four observations are, first of all, that the authority of the Health Services Restructuring Commission, in our view, will be needed in some Ontario communities which have not achieved a voluntary restructuring plan. We don't think it will be necessary in all, but certainly we see that in some communities this will be the case. We note that this commission in essence was recommended by the Metropolitan Toronto District Health Council in terms of its report.

We do believe that the Ministry of Health approval of a \$48-million capital grant recommended by the Essex County District Health Council for the two remaining hospitals in Windsor will prevent the need for this legislation being applied in Essex county. When I say \$48 million, that assumes there will be \$24 million raised locally, and that does constitute the \$72 million that will be needed to take the four hospitals and fit them into two remaining acute-care sites.

A third observation is that while Bill 26 appears to provide greater authority for local municipalities to integrate services, it appears also to centralize decision-making in the health sector. It provides no framework or mechanism for integrating health services at the local level. We believe this is contrary to trends in terms of organizing health care across Canada and, for that matter, North America where integrated delivery systems are emerging as a model. Even in an environment like the United States, which we all agree is not appropriate in terms of not having a single-payer model and a universal health system, it is working in places where there are whole populations being served. It's proving to have a tremendously beneficial impact on the health of those populations.

Finally, we would note as an observation that the Health Services Restructuring Commission does not have authority for broader health system restructuring issues, in our view. It would be more aptly described in the legislation as hospital services restructuring as opposed to health services restructuring.

In terms of our recommendations, the first is that we ask that the committee and the government recognize the urgent need to promote the development of integrated delivery systems at the local level. If it would help, we have operationalized a definition, which is taken from the literature, that we feel would guide our thinking on this issue. We define an integrated delivery system as: "A network of organizations"—in other words, it's not a single board, it's a network of organizations—"that provides or arranges to provide a coordinated continuum of services to a defined population"—and in the case of Essex that would be the population of 350,000 in Essex county—"and is held clinically and fiscally accountable for the outcomes and health status of that population."

Our second recommendation is that the vital importance of integrating primary care and physician services with local integrated delivery systems be recognized as critical to their success. We believe health should be a non-partisan issue. We also believe that previous governments have struggled with the whole notion of how to integrate primary care into the series of reforms that certainly were very evident under the last government. We urge the new government not to ignore the need to integrate primary care into the full system.

With that in mind, we encourage the committee to take a look, if it hasn't already done so, at the work done by the chairmen of the colleges of family medicine in Ontario and the university faculties of family medicine. They have really put together some exciting recommendations in terms of how primary care can be integrated. They point out, for example, that 93% of all residents of Ontario can name who their physician is. We believe that with that kind of recognition, all members of the population could be rostered with primary care organizations, and that more than anything might lead to the kind of integrated delivery systems that we think ought to emerge.

Our third recommendation—and this was referred to by the Windsor and District Labour Council—is that provincial workforce adjustment policies must be in place before health system restructuring recommendations can be fully implemented. It's absolutely vital that these kinds of policies be in place and clearly understood and that the funding mechanisms be clearly understood so when we do downsize the institutional sector, which we're right on the edge of doing in Windsor and Essex county right now, we have the policies in place that will ensure that clinical teams stay together, that will ensure that the community health sector, which should continue to grow in size notwithstanding the budgetary restraints, will be able to benefit from some of the skills associated with these people who have given so much in the hospital sector.

Our final recommendation is that successful hospital restructuring cannot occur in the absence of a strong, well-integrated network of community health services. We strongly believe that some of the savings from hospital restructuring must be reinvested at the local level on the basis of district health council needs-based plans.

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With that in mind, we would urge the committee to recognize that district health councils should be recog-

nized in the legislation, both in terms of any recommendations that go to the proposed Health Services Restructuring Commission and, for that matter, any community reinvestment that will be directed at those communities that are relatively underfunded, like Windsor and Essex county, and that have taken the initiative to restructure and downsize their institutional services.

With that in mind, one of the thoughts that occurred to me, in listening to the discussion earlier today, was that Bill 173 passed by the previous government did amend section 8.1 of the Ministry of Health Act—I believe that legislation is still on the books—and that legislation described the functions of district health councils very specifically. Clause 4(c) of that legislation specifically said, “The functions of a district health council are...to make plans for the development and implementation of a balanced and integrated health care system in the council’s geographic area,” and that is what this district health council has been struggling to do over the last four to five years. Thank you for this opportunity.

Mrs Ecker: Thank you very much for coming forward with an excellent presentation and some very excellent suggestions.

As you probably are aware, other provinces, when they got into the restructuring exercise, actually passed legislation to completely scrap all hospital boards across the entire province, which we didn’t think was a very appropriate way to go. We recognized that the voluntary boards and the hospital boards are important components of the system, as are district health councils, which are very much a component of the system. As you probably know, under section 8.1. in the current legislation, which is not being changed, the DHCs have the power “to advise the minister...”, “to make recommendations on the allocation of resources” for local areas, “to make plans for the development and implementation of a balanced and integrated health care system...” and “to perform any other duties assigned to it under this or any other act or by the minister.” I think that is very clear.

What I think I hear you saying, however—there are three things, and I just want to bounce them off you to make sure I’m hearing what you’re saying. First, you would like us to increase the power of the district health council in effect by giving it specific status in terms of basing restructuring decisions on those recommendations.

The second issue—did I understand you correctly that you would actually like us to broaden the mandate of the commission to include community-based services in terms of the restructuring as well as hospital services?

Sorry I’m getting into a lot of points, but the final point was, given the fact that the minister has agreed to sunset the commission within four years and some presenters here have said they think that’s appropriate, do you believe we can get the restructuring within Ontario done? Given the experience you’ve had out here, can we get the restructuring done which everyone recommends and agrees needs to be done within that four-year time frame?

Mr Martin: In answer to your first question, I don’t think the issue is so much strengthening the mandate of district health councils. The strength of this district health council in Essex has been that we have been a neutral

body made up of volunteers from the community who are here to serve the best interest of the community and not any specific stakeholder in the health care system.

The thrust of these remarks was to encourage the government to promote the development of an integrated delivery system that does need to have primary care, mental health, long-term care, acute care, rehab care all connected in a comprehensive way.

The issue of mandate for district health councils does need to be clarified. It needs to be specified clearly what that mandate will be. But I’m not sure I would use the word “strengthen.” We have had a role that has been well recognized and well supported, and if that continues, I think we will have the tools necessary to do the work.

In terms of broadening the mandate of the Health Services Restructuring Commission, I view that commission as representing a major centralization of authority, and I don’t think it makes sense, necessarily, to broaden the mandate of that committee to include community-based services. I think the tools are there without that additional legislative mandate. But what I do believe is that the government has to provide envelope funding, probably at the local level, to ensure that the integration that has to happen will happen.

Mrs Caplan: Nice to see you. Excellent presentation. I can only imagine the frustration that you have when you’ve got a plan and it’s ready to go. In the context of the total resources spent in Windsor-Essex county, waiting for those capital dollars must just be driving everyone nuts: “Here is the plan. The community did it itself.” I thought you were very diplomatic when you said you don’t need the hospital restructuring commission. You’re absolutely right that it’s about hospitals; it’s not about any kind of restructuring of health care.

We’ve heard very clearly from the minister that it is his intention to turn back the clock on the district health council mandate. My question is this: Was your mandate 20 years ago the mission that you’ve put forward for us today? Would you have done 20 years ago, not that you were there at that time, but do you remember—as I recall, DHCs were advocates in the community for additions.

Ms Johnson: Actually, we can see our mandate broadening daily and changing. I’ve spent now two and a half years at the health council. I have seen nothing but change and a broadening of our mandate. That broadening is coming basically from the community and from the partners. They’re looking for direction. They’re looking for somebody to sort of be not necessarily a central authority but a central coordinator-facilitator type of thing. That’s the growing role of the health council in Essex county. I don’t know that that’s happening in the rest of the province, but it’s certainly happening here.

Mrs Caplan: I agree entirely with your desire to have that mandate clarified as part of the process of this legislation, because in the absence of that process and the fact that the minister’s been very clear about returning the district health councils to the role of 20 years ago, it would be a terrible setback for community participation.

The second point I wanted to make was, I very much support your definition on the network of organizations

providing innovative services. To me, that that's the definition of a comprehensive health organization.

Earlier today there was a discussion about allocation of resources that would come from savings. I guess I hear you very clearly saying that the local community can tell you what's going to work in their community, and it's the centralization of power that we see in Bill 26 that runs contrary to that local coordination that's needed. Is that a fair categorization?

Mr Martin: In our case, certainly we are in the middle of a project called improving community health. We will have recommendations ready by late this summer in terms of where funds should be reinvested. We think it's important that some of the reinvestment should be made on the basis of local decisions and we think that those will be better decisions if done on that basis, provided it's consistent with provincial policy, and there's no reason why that wouldn't be the case.

Mrs Caplan: The last point I'll make, and then I'll turn to my colleague, is that I was the person who was there when your discussions on reconfiguration began. I am saddened personally to see Windsor not held up as a model for the province and encouraged and supported. I despair that you've been put through the agony that you have over the last year. I hope they will just get on with using you in a positive way as a model and as a reward to your community that has done it all by itself.

Mrs Papatello: I wanted a quick question, Hume. This morning's presenters from one of our hospitals indicated that, "Redirect savings from hospital restructuring to community programs based on provincial priorities and allocated to the ministry rather than through a local allocation process," which is sort of opposing my thought and yours that in fact it should be done on a local level. Can you give me a quick comment?

The final summary is that this government did get itself elected on the basis of no cuts to health care—you have to agree, then, that there have been cuts in health care—and they were also elected on the basis of returning 10% of casino profits to a city like ours. We could get our reconfiguration done in 480 days, if that were the case. That was pointed out to me by my colleague. I just wanted to throw that out; but specifically, local decision-making in the reallocating of community service dollars, if you could comment.

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Mr Martin: Certainly. I think there's been a bit of a misconception in terms of the history of this. The Win/Win report always suggested that there would be \$22 million reinvested in community services, which was roughly estimated as being 10% of the savings coming from the hospitals when they consolidated on two sites. In fact, the Win/Win report suggested that might be an underestimate of the kinds of savings that would accrue, and in fact research coming out of the United States suggests that anywhere up to 30% savings can be reinvested with proper integrated systems and the removal of duplication.

Mrs Papatello: Yes. That was before the 10% cut.

Ms Lankin: I'm going to follow along the same lines. You might have a chance to combine what you were going to respond to Sandra's question with mine. I'm

finding it almost amusing when I go from community to community and hear each of the communities say, "Well, we're actually proceeding fine with our restructuring and we have consensus and we know where we're headed, but you may need these powers for other communities." So I support the powers that are there.

Let me tell you my concern about the powers as they're set out. The restructuring commission doesn't have any terms of reference. There's no mandate set out and there's no limit on its power and there is no linkage to the reports or the processes driven by local health planners, usually, through a DHC-led process. I've heard assurances from the government, "Well, that's what we intend to do," but that's not at all clear in the legislation. I can give you very quickly examples of where the minister has in fact come into communities which were well on their way to implementing consensus reports and the actions of this new Minister of Health have in fact stalled the implementation of those reports because he has taken steps that have broken down the consensus. So I feel a need to see the terms of reference in the mandate and the linkage set out to ensure that there's a framework for what we're doing.

A last comment on that: I'm sorry, but I don't know what this government's philosophy is with respect to restructuring of health care. It's not clear to me at all that they're looking at determinants of health. If I look at everything else they're doing in terms of cuts they're making, where they're making them and the effects on people's health—not determinants of health. It's not clear to me, given that the early reinvestments that are being made are in extension of cardiac care and other services in hospitals, as important as those are, that they believe in the shift from institution to community or from illness treatment to illness prevention and health promotion. They haven't told us what their framework for restructuring is other than to save bucks and to reinvest it: "We'll save them now and we'll reinvest them some time in the future." Could you comment on the proposal for those kinds of linkages to be built into the legislation?

Mr Martin: In terms of the linkages, we do believe there should be reference to the commission being required to consult with local district health councils before using the powers that are assigned to it in the legislation. So there should be that linkage with local planning.

In terms of the question around reinvestment of savings, the current government has said that the health envelope is sealed. We believe that even though clearly there have been reductions announced for hospital budgets that are going to be very difficult to manage but which we, as a community, are in a much better position to manage because of the steps that have been taken by the hospitals and the medical society and the district health council, within a year or two there will be that reinvestment possibility surface, given the government's commitment to keep the envelope sealed, and we believe we will be in a good position to make advice in terms of that reinvestment on the basis of the current project we're involved in. We hope, again, that the government will give us that possibility, because we believe that the recommendations will make a lot of sense, in terms

particularly of areas like children's mental health, women's services and children's services.

Ms Lankin: In fact, if the total restructuring reports aren't adhered to, if it's only the downsizing of hospitals and saving of the money and not the reinvestment in the community, in many communities there will be very large gaps in this system. These people are looking in those reports to relocate services from institution to community. I understand that you've heard that commitment that the health care envelope is sealed and that you believe in that commitment. I hope your belief is well placed.

Let me ask you a question. The word around Queen's Park these days is that a section of the Ministry of Community and Social Services, particularly dealing with children and children's mental health, whatever, will be moved from that ministry over into the Ministry of Health and that its budget, downsized as it is, will be brought over with it and that in fact that will be subsumed within this \$17.4 billion; in other words, a dramatic cut to the actual health care budget. Would that meet your belief of what the government's commitment to seal the envelope is?

Ms Johnson: If I may, Hume is an employee of the government; I'm an appointee.

Ms Lankin: No, he's an employee of the district health council.

Ms Johnson: I don't think he should be put in the spot of answering that. As far as the commission is concerned, I myself had some serious thoughts about the lack of any kind of mandate or organizational structure or goals set forward. That left me wondering what that commission would be all about. But I would issue a word of caution, that if in fact the government plans on using that commission to go in and ram through hospital restructuring and/or any kind of community restructuring, I don't think that would work. Quite frankly, after two and a half years on the health council, and knowing all of the skills and the careful structuring that had to take place in order just to bring all the partners to the table and get them to begin to talk to one another and build some trust, because there was no natural trust that had ever been built between the institutions and the agencies, and all of my time at the district health council has been spent working on those types of endeavours, a commission that comes in from outside and lays down the law and says, "Here's what we're doing. Go do it," I suggest would not result in successful results.

The Chair: Thank you for the presentation. We appreciate your involvement in our process.

Mrs Caplan: As is our practice, I would like to place a question at this time to be answered. This presentation raised the issue of provincial workforce adjustment policies and suggested the need for a transitional fund. Given the fact that the government cancelled the workforce adjustment fund as one of its first acts upon assuming government, my question is whether there is an intention of the government to bring forward provincial workforce adjustment policies; and secondly, whether it is going to reinstate the workforce adjustment fund in order to support the restructuring as contemplated by Bill 26 and, if so, when we can expect to see that.

The Chair: I'm not sure the Minister of Health can answer that question, but we'll certainly direct it to them.

Mrs Caplan: He probably couldn't, and that's why I have the worries about this bill.

Ms Johnson: I'd just like to make a parting thought or comment. That is part of the necessary structure for restructuring the community. You cannot do that without the labour people. The people whose jobs are to work in the hospitals and work in the agencies absolutely will not come to the table. In fact, the labour people in this community have left the table because they could not trust what was happening with the government when the government refused to give us the \$109 million which was the original commitment. Labour has left the table here, and you will not even get them at the table in the rest of the province if there is no money and no planning in place.

The Chair: Thank you very much.

1430

ESSEX COUNTY PHARMACISTS' ASSOCIATION

The Chair: The next group is the Essex County Pharmacists' Association. Good afternoon. Welcome.

Ms Yvonne McRobbie: Good afternoon, Mr Chairman, ladies and gentlemen. I am the president of the Essex County Pharmacists' Association. With me are Tim Coughlin, president-elect of our association; Dave Malian, president-elect of the Ontario Pharmacists' Association; and Sal Cimino, our district 11 representative of the Ontario Pharmacists' Association. We are all practising community pharmacists here in Windsor. We have been asked to speak to you on behalf of the board of directors of the Essex County Pharmacists' Association, representing the 160 community and hospital pharmacists of Windsor and Essex county. The goals of our organization are: (1) to serve the public, (2) to serve the profession of pharmacy and (3) to provide continuing education for our members.

We recognize and agree with this government's need to bring Ontario spending under control. We have, however, grave concerns that some measures put forward in Bill 26, the Savings and Restructuring Act, will not be in the best interests of the public, especially those in greatest need, seniors and social assistance recipients. We are pleased to be able to express our concerns to you at this public forum. The areas of concern that we would like to address are: (1) the introduction of copayments, (2) the deregulation of drug prices and (3) the limitation of a formal negotiation process with the pharmacists of Ontario through the Ontario Pharmacists' Association.

Copayment: Under this bill, seniors earning less than \$16,000 and couples earning less than \$24,000 and social assistance recipients will pay a copayment of \$2 for each prescription filled. Seniors earning over these amounts will pay the first \$100 in prescription costs each year per person and then the Ontario drug benefit dispensing fee of up to \$6.11 per prescription.

We are concerned that the proposed system will result in the following: (a) a financial hardship to seniors on a fixed income and social assistance recipients, (b) an increase in non-compliance of medication therapy, which

may lead to higher-cost health care interventions, (c) an increase of stockpiling of medications, and therefore an increase in wastage, (d) concern of privacy issues and (e) the cost to implement and monitor this program.

First of all, financial hardship: Already a community pharmacist on our board has reported being approached by one of his senior patients who is quite fearful of the impact of this legislation on his health care. This senior has an income of \$16,200, which is slightly above the cutoff for the \$2 copayment. He presently requires 45 prescriptions per year. Under this legislation, his medication copayment would be approximately \$350 per year. If his income was \$200 less, then he would only pay \$90. This senior now must make a decision to reduce his income or do without some of his medication.

Residents in nursing homes are subject to this \$2 copayment, also with a limited discretionary income of approximately \$100 per month. These seniors must make all their personal purchases, including clothing, possibly incontinent supplies, personal care items and now prescription copayments with this income. The average nursing home resident receives five medications monthly, but it is common for some to be on 10 or more per month with chronic illnesses like Parkinson's disease, diabetes, congestive heart failure and high blood pressure. This could easily take up 20% to 25% of the residents' monthly allowance in copayments. Often in these instances the physician may require changes to dosages and drugs in order to get the appropriate medication therapy and regimen. This may become quite costly to these individuals.

Non-compliance: Copayments will not reduce the need for medication. Seniors and social assistance patients who have high blood pressure may think they do not need their medication because they feel well. As a result, if left untreated, more serious health problems may occur that could result in hospitalization and increased costs to our health care. Low-income parents of a child having a chronic illness such as asthma may decide not to fill certain medications due to cost, which may result in repeated hospitalization. Should the physician treating a patient in a nursing home be required to make a medical decision in a patient's treatment that could jeopardize their care on the basis of cost? United States statistics indicate that the cost of non-compliance is tremendous: \$25 billion in hospital admissions and \$5 billion in nursing home admissions.

Stockpiling and waste: The average price for medications filled under the Ontario drug benefit plan is \$33.40. This consists of the cost of the drug of \$27.31 and a professional fee of \$6.11. As you can see, \$6.11 represents just 18% of the total cost, while 82% is made up of the cost of the medication. Much of the cost to the Ontario drug benefit plan has increased due to the cost of the medication itself and the introduction of newer, more expensive drug treatments, especially for cardiovascular and gastrointestinal diseases.

It is understandable that someone who has to pay a \$6.11 copayment would want as large a quantity as possible. If you look at a popular antihypertensive medication with once-a-day dosing costing \$1.02 per tablet, a 100-day supply would be \$108.41. The senior

pays \$6.11 and finds that after a couple of days he or she cannot tolerate the side-effects and discontinues the medication. This treatment failure has cost the Ontario drug benefit program \$102.30. The remaining tablets will likely end up in the medicine cabinet cleanup and be destroyed. Something else will be required for the patient so another drug will be prescribed. Will this one work, or must we try a third or fourth medication? Medications are discontinued for a number of reasons, including ineffectiveness, side-effects, dosage change due to change in medical condition, and drug interaction with new drugs added to the therapy.

The Essex County Pharmacists' Association, as a public service, has conducted a medicine cabinet cleanup annually over the past 15 years. In each of the past five years we have collected 14,000 unused prescriptions for destruction, with a value of \$215,000. Approximately \$60,000 was paid for by the Ontario drug benefit plan. This would represent the \$2 copayment for 30,000 prescriptions. This is only what was brought into our pharmacies in a two-week period. What remains in seniors' homes or in nursing homes as a total of unused medication is unknown. There are more cost-effective ways of saving this money rather than putting the burden on seniors.

1440

In this area, we applaud the government's initiative to limit quantities dispensed to 100 days and we would encourage the government to discuss with the Ontario Pharmacists' Association the concept of trial prescriptions. This would greatly reduce waste and save health care dollars. In a study in British Columbia in February 1993, a seven-day supply trial prescription program showed that over 50% of prescriptions were never filled after the initial prescription was taken.

Privacy issue: In my local pharmacy, I can see two senior neighbours coming in at the same time to pick up their prescriptions. I charge one \$2 and I charge the other \$6.11. Clearly, the message to them under this two-tier system is that they are in two different income categories.

Implementation: How will the government accurately determine each senior's income and have this input into the pharmacy network by June 1, 1996? How will any updates be monitored and changes implemented? What will this cost? How can seniors be sure that the right copayment is being charged? How will nursing home patients pay for this medication?

We believe this government's introduction of copayments for prescription drugs will not reduce health care costs for the future. We believe substantial savings can be realized through the introduction of trial prescriptions and elimination of waste. A more equitable program may be developed, much like an insurance plan in which seniors could join with an annual premium. If further measures were required, then consider Mr Harris's fair share health care levy as proposed in the Common Sense Revolution where individuals are asked to pay a fair share based on income.

Our local Council on Aging has asked that we express their concerns as well on the issue of copayment:

"The Council on Aging, Windsor-Essex county, is concerned about the changes being made to the Ontario

drug benefit plan. The fear is that older adults might choose to extend their prescriptions by taking them less often or eliminating them, thinking that they don't feel 'that bad.' This is because of the 'minimal fee.' In the long run, there will be an increased cost to the health care system because those who might have been easily maintained on medications in their own homes will now be hospitalized. Seniors are the province's greatest resource and have contributed to its development over many years. They deserve the best and most equitable health care system available. This is not to ignore the difficult economic times we face, nor to underestimate the impact of the health care budget on the overall economy. We must be careful, however, to look at the full picture and decide whether pennies saved today will cost dollars tomorrow."

Deregulation: Health care costs should be fair and equitable to all Ontario residents. Under the proposed changes, the government will continue to set the price for a drug product by an agreement with the manufacturers for drugs dispensed through the Ontario drug benefit and Trillium programs. It will eliminate any restrictions on the price that drug manufacturers can charge pharmacies and hospitals for products to be dispensed to non-Ontario-drug-benefit patients. This means that independent pharmacies, chains and hospitals will have to bargain individually with drug manufacturers, and some will get better prices than others.

Is it fair for consumers in one part of the province to pay more for a prescription than others? How much is fair? Will prices go up or down with deregulation? If prices go down, wouldn't it make sense for the government to deregulate drug prices for everyone, including the Ontario drug benefit program? If prices go up, who bears the cost?

There are about 2.5 million people in Ontario with no drug insurance. Fifty-five per cent of Ontario residents have some type of private insurance. However, price increases will affect the benefit packages the employer can provide. If government by definition has the best available price for medication, why not keep this accessible to all Ontario residents?

Negotiation process with the Ontario Pharmacists' Association: Under the proposed changes, the government will eliminate the negotiation process with the Ontario Pharmacists' Association, or OPA. The government will unilaterally set the maximum professional fee for Ontario drug benefit program prescriptions by regulation.

The Ontario Pharmacists' Association represents over 4,500 pharmacists in Ontario practising in independently owned or chain pharmacies, hospital pharmacies and industry. The government has not attempted to negotiate with OPA under the present legislation. Instead of eliminating the process, we would ask that an attempt be made to have the negotiating process work for both parties. We also think that a forum to discuss other issues would help both parties. Some of these topics are cost containment, trial prescriptions, intervention programs, drug utilization reviews and drug information services.

In Essex county, we have conducted an intervention study to determine the extent and type of interventions that community pharmacists make and to estimate the

benefit in economic and health care terms. In an eight-month study, 1,348 interventions were documented. Of these, 222 had a cost savings of \$10,820. In Essex county, we also have formed a Pharmacy Task Force on Prescription Cost Containment, bringing together all the stakeholders—physicians, employers, union leaders and benefit consultants, as well as pharmacists—to explore ways of containing and/or reducing costs to employers. Employers seek us to help them with drug utilization reviews and suggestions to make their drug benefit plans more cost-effective.

Would it not make sense for government to work with the Ontario Pharmacists' Association to achieve long-term control of costs of the Ontario drug benefit program? OPA has the tools to help. Pharmacists in Ontario need a voice that will speak on their behalf in order to improve the level of pharmaceutical care to the consumers of this province. We ask that the Ontario Pharmacists' Association be that voice.

In conclusion, we would ask that you amend Bill 26 in order to: (1) eliminate copayments as proposed and utilize cost savings and, as proposed by the fair share cost levy, if necessary, (2) maintain fair and equitable drug costs for all Ontario residents, and (3) create an effective process through the Ontario Pharmacists' Association for the profession of pharmacy to have a voice in their future and that of the drug benefit program.

Mrs Pupatello: I understand from a group of pharmacists speaking yesterday that in fact no members of the Ontario Pharmacists' Association were consulted in any manner at any time prior to Bill 26 becoming public knowledge. I'd like you to confirm that, and also tell me the differences or changes you anticipate as a small drugstore, or not one of the large chains. What are the changes? What's going to impact you in terms of a business, given that the Conservative Party is supposedly in favour of business, and particularly small business? What happens to small business pharmacies when you do not have the huge buying power of the large chains and the drugs become deregulated? Of course, we anticipate that drug prices go up. What kind of pressure are you under to absorb that copayment so that your clients are coming back to you etc? Would you comment on both?

1450

Mr Dave Malian: Yes, I can do that. We did meet with the Minister of Health back in September, and at no time during our discussion with him did he indicate to us what changes were going to be occurring to the Ontario drug benefit program. As a matter of fact, he indicated to us that he was very supportive and he would like our help in decreasing costs. We were not consulted at all regarding these changes.

On the question about smaller pharmacies, I don't know. I don't think anybody really knows. The concern we have with deregulation of drug prices is that the independently owned pharmacy in Wawa, Ontario, may not necessarily have the same price advantage that the pharmacy in London or Toronto would have. So we're concerned about some of those smaller independent pharmacies having that same type of competitive advantage.

Mrs Pupatello: I'd like to put those same questions that you've asked on the table so that we may get

answers from the minister: How will the government accurately determine seniors' income and have this input into the pharmacy network by June 1, 1996? How will any update be monitored and costs and changes implemented? What will this cost, and how can seniors be assured that the right copayment is being charged? How will nursing home patients pay for these medications?

Those are such valid questions, I'd like to have those tabled and a response from the ministry as soon as possible.

Interruption.

Mrs Pupatello: Oh, I think they had lots of discussion with that group. Thank you.

Mr Crozier: I'd like to go a little further into deregulation. I'm concerned about those who have been emphasized and what it's going to cost seniors under the Ontario drug benefit plan, but what about all those people out there who aren't covered by a drug plan, who may be seniors, who may be the working poor, and what deregulation may do to them because they don't have the Ontario drug benefit plan to bargain for the cost of their prescriptions? Where do you see deregulation going, in your professional opinion?

Mr Malian: We're quite concerned that we think deregulation will increase drug prices. We think that if the government felt the same way, then they would have deregulated the prices on the Ontario drug benefit program too.

Mr Marchese: I want to thank the group for the submission and the number of suggestions that you have made. I know that in Peterborough a number of pharmacists have said very much the same thing in terms of what it would do under the whole issue of user fees, for example. You outlined and defined six areas where you have concerns, and I hope the government members will take that into account.

Also, I'd agree with your conclusion that "Instead of eliminating the process, we would ask that an attempt be made to have the negotiating process work for both parties." It's my belief that when people are working together, we have better solutions, and that when governments act unilaterally, we have problems, not just for yourselves but for everybody else affected.

You raise an interesting issue about trial prescriptions which interests me. Would it mean that if you give a prescription for seven days, the individual doesn't have to go back to the doctor and you would fill them automatically, or would they have to visit a doctor again?

Mr Malian: No. The whole point of trial prescriptions—and we do have studies, as Ms McRobbie has indicated, that have been going on here in Canada, in British Columbia. In the trial prescription program, a physician would write a prescription and the pharmacist would only fill a week's supply. It gives the patient some time to adjust to the medication and also to find out whether the medication was helpful. If the patient didn't feel comfortable, then they certainly can go back to their physician and another medication would be chosen. If after seven days they're feeling good, then the complete medication would be filled.

Mr Marchese: I understand, yes. I personally find that very attractive. My mother is 84 years old, and I know

often doctors prescribe many pills. She takes them, takes them home and sometimes realizes the effect of it is either good or not good and she may not take them any more. So we have a whole load of wasted pills. I think it's a very useful suggestion to pursue.

You didn't comment on other areas of this document that I know you might have wanted to; I'm not quite sure. I appreciate that you covered areas of interest, but is there anything in this document, Bill 26, that you want to speak to generally with respect to whether it contributes to the betterment of our health system or not?

Mr Malian: We found it difficult to just take the pharmacy portion of that document and try to understand that. But we have concerns, as a citizen of Windsor, of the whole Bill 26. Yes, we do.

Mr Marchese: It's a very good point again and it brings me back to the comment the doctor made in Peterborough, again, when asked a similar type of question. He only understood a third, I believe he said, of this entire document. This man is quite literate. It obviously means there's a hell of a lot of incomprehensibles here, meaning people need a great deal of time to understand them. The fact that they're so complicated makes it impossible for people to participate.

Thank you for your submission.

Mrs Johns: Thank you for your presentation. I don't know if you were here when I asked the last question, but I asked one of the previous presenters about the delisting of drugs from the formulary. I'm sure that many of you were pharmacists in 1993 when the last delisting happened. Can you comment on the effect of the delisting that happened in 1993 with your clients, which basically implies a 100% user fee, versus \$2, when considering taking drugs less often or eliminating them altogether from their portfolio of drugs that they take?

Mr Crozier: Because they're going to put them all back on.

Mr Malian: Sorry. Can you just repeat that for me again? I'm sorry. I want to make sure. We're talking about delisting of products from the formulary that's been occurring since the program first began, not just in 1993.

Mrs Johns: It's happened a number of times; that's right.

Mr Malian: The formulary is an ongoing process.

Mrs Johns: So one of the things we could have done was we could have delisted drugs off the formulary and not charged the copayment. What we did was we decided to charge a copayment. In your statement you suggested that their taking drugs less often or eliminating them would be one of the results of the \$2 copayment. I want to know if that was a result of the delisting also.

Mr Malian: No, delisting's been going on since the program began, back in the early 1970s.

Mrs Pupatello: The Davis era.

Mr Malian: The program is an ongoing program. Products are delisted and added to the program consistently. So whether it's 1993 or 1980, drugs have been added and brought on, and that will not change. Now, whether you delist more products—then you might as well not have a formulary any more. They've delisted enough products now that the formulary is actually quite small in comparison to community-based formularies.

What I'm trying to say is that delisting has been going on since the day the program began. We've added drugs and we've deleted drugs, or the government.

Mrs Johns: Do you want to add to that?

Mr Sal Cimino: Yes. Dave makes the right point. A lot of the deletions were not to save money. A lot of them were because drugs have changed. We've got new drugs. Why use something old that doesn't work as well?

In today's formulary, I think the last deletions, on a personal view, were done very well in the sense that lifestyle drugs were hit somewhat, where you're taking a drug three times a day now rather than when it was once, but that was a bit of politics and a bit of savings of money. Just a few of those happened. The other ones were basically because the drugs are new that were developed, and they work much better than the ones that were developed 30 years ago. That's why the deletions occur. It may cost more, because developing a drug today is a hell of a lot more than it was 30 years ago.

Mrs Johns: I just want to ask you a question about the medicine cabinet cleanup. Every place we've been, people have talked to us about it, collecting lots of unused prescriptions, \$215 million I think you said.

Ms McRobbie: Thousand.

Mrs Johns: That's \$215,000 brought in during two weeks. If we went to a trial prescription like you're suggesting, you've outlined what's good about it to the consumer of the product. Can you outline the cost there would be to the taxpayer for that?

Mr Malian: Under this present legislation, we know if this goes through you won't have anybody to speak to on this, okay? If you're interested in trial prescriptions, then I hope the negotiation process with the Ontario Pharmacists' Association will be able to continue, because if not, you won't have anybody to talk to about it.

We feel trial prescriptions can save costs in the long run for the taxpayer. BC has an excellent pilot program out right now and studies are coming back right now showing a considerable cost. If you'd like, we can get that kind of information for you. We've asked. We've told the minister we have that information, and so far they haven't looked at it, I guess.

The Chair: Thank you for your presentation this afternoon. We appreciate your interest in our process.

While our next presenter is coming forward, we're going to have just a quick three-minute recess.

The committee recessed from 1500 to 1503.

FRED NETHERTON

ART KIDD

The Chair: Folks, if we can get back to the table, we'll listen to Dr Netherton, our next presenter. One of the dangers of a recess is that it takes a little while to get things back under control, but we're almost there.

Dr Fred Netherton: Thank you for allowing me to speak today. I'd like to start by saying that I did meet Mike Harris about three years ago and I was impressed; I thought he was sincere and interested in Ontario. But I don't agree with his bill. I agree that Ontario has some problems and some changes are necessary. I also under-

stand that the government wishes to get the bad-tasting medicine out of the way early so they can bring on the sweets in a few years. However, I do not agree or understand why the last 30 years of progress have to be destroyed to accomplish this.

In reading excerpts from Bill 26, the most often heard phrases are "the minister would have the power" and "no right of appeal." The bill contemplates all power at one point, with no right of appeal, no assurance of job security and no due process of law.

I was born and raised in Ontario and always felt that the government was here to serve the people, not the people to serve the government. Ontario is a diverse province with problems varying with the different areas. In Essex county, we have made great strides in improving efficiency and saving money in the health care system while maintaining excellent patient care. Since 1991, the hospitals and physicians have restructured health care in Essex county. We have gone from about 1,200 beds down to the 700 range with no loss of programs. This has only been possible because of cooperation and trust between the hospitals and physicians. I feel that Bill 26 will certainly destroy this spirit of cooperation.

As a radiologist, I have three specific concerns. The first one is concerning the Independent Health Facilities Act. X-ray offices are independent health facilities. We are inspected twice a year for X-ray safety and every five years for everything else. We are like a hospital that has an accreditation inspection, only our inspections are not voluntary. I feel we are overregulated as it is.

To set up an X-ray office takes anywhere between half a million and one and a half million dollars and can employ up to 20 people. It's very labour-intensive. This is a very large commitment to make if there is no assurance that you can stay in business after the end of the year. With Bill 26, any office can be closed at any time with no right of appeal—always with no right of appeal. It is reasonable to close facilities that are a danger to patients or that are substandard; it is not reasonable to dangle my livelihood on a political fishing line that can be cut at any time.

Not only will Bill 26 close facilities for any political or non-political reason, but it will allow the minister to have any specific person open any facility anywhere the minister chooses.

Taken together, this sounds as if we'd better get one of my partners involved with each political party to try and cover our bases. These changes will obviously lead to open political patronage, as far as I can see. I would suggest that clinics be opened or closed only on medical grounds: medical safety to close them, medical need to open them—nothing else.

The section on removing limitations on foreign for-profit operators is also a great concern. Right now, 50% of outpatient X-rays are done in private offices. I feel the government probably could get the job done cheaper if it did contract all outpatient services to an American, for-profit HMO, but the foreign firm is going to have to make money. I think they make about 30%, though I may be wrong. So what are they going to do? They're going to demand the closure of existing offices, which the minister can do with the existing legislation. This would

produce great hardship on physicians but also on the hundreds of secretaries, receptionists and X-ray and ultrasound technologists we employ. HMOs from the States do not hire the same numbers back again. They would probably do it with about 50% of the number we use. There goes a large number of jobs. The other large group to suffer would be patients. Convenience, with local and rapid diagnosis, would definitely be lost.

I would expect a Conservative government to help private enterprise, not kill it. Why would anybody want a foreign firm to take money out of Canada, and why would you want to kill jobs that keep the money and taxes in the community? I suggest that the preference for non-profit Canadian operators be maintained.

The third concern is over the necessity for a specialist to be affiliated with a facility. I'm not really sure on my reading whether this means it has to be a hospital. If it does, it's going to create a problem. Twenty per cent of Ontario radiologists work only in private offices. Actually, in Windsor, there are five groups with private radiological offices, and only one has a hospital affiliation. Patient care would not be served by forcing these doctors to work under the auspices or at the convenience of hospital administrators. With the powers of the College of Physicians and Surgeons watching us and ordinary market forces, I feel confident that so-called specialist affiliation will not add anything to medical care and should be dropped.

I'd like to introduce Dr Art Kidd, who also has a few comments, and then I have a few at the end.

Dr Art Kidd: Thank you for allowing me to speak today. I wish to comment on a few general aspects of Bill 26, the Savings and Restructuring Act.

To introduce myself, I am currently an endocrinologist who has been practising here in Windsor, my home town, for 15 years. I have been chief of medicine at both the Salvation Army Grace Hospital and the Hôtel-Dieu Hospital for a total of eight years. I have served on and chaired virtually every possible committee at those hospitals, and I have been the chairman of the research ethics committee for the local cancer foundation for five years. I am the former president of the local Academy of Internal Medicine, and I am the immediate past-president of the Essex County Medical Society, which represents over 400 physicians.

My appearance today is simply further evidence that I am committed to quality health care in Windsor, Essex county, Ontario and Canada. I am here because I believe that many elements of schedules F, G, H and I which impact on the provision of health care will undermine the health system it is intended to improve.

1510

It is not my intent to reiterate in any detail the many concerns that physicians have with Bill 26. You have already heard many times about our fears for the confidentiality of our patients' charts, fears about interference with the patient-doctor relationship, fears of bureaucratic second-guessing of physician practices, fears of absolute ministerial control of hospital or physician services and fears about the intent to repudiate previous collective agreements with the Ontario Medical Association, to name just a few.

I would like, however, to provide some local perspective with regard to these issues. This community, through its district health council, has been engaged in a process of voluntary reconfiguration of both hospital and community health services to improve efficiency. This has been a long and difficult process and much has been achieved through the strong efforts which have required mutual trust. The Essex County Medical Society has taken an active role in promoting these changes because we believe in promoting efficiency and cost savings for local health care. Incidentally, we do 95% of all health care right here in this county.

The Essex county society has concerns, however, that the new ministerial powers granted by this act would threaten the cooperation, as different institutions would see it to their advantage to gain favour with a minister who is able to unilaterally determine which hospital or organization will provide which services. The minister could also designate which physicians could work at a given site, effectively negating the importance of local experience and expertise.

The concept of remote manpower decisions is especially frightening in light of our experiences during the reconfiguration process. Repeatedly, we have noted locally that data emanating from the ministry and other consultants are badly flawed and do not accurately reflect Essex county situations. In virtually every situation, the data overestimate the number of physicians working in our county. Some of these errors are understandable and forgivable, but some are incomprehensible.

I may occasionally make a mistake in counting, but as someone with 25 years of experience in medicine and someone with six kids, I think I can accurately estimate the gender of each and every one of my colleagues. With this in mind, I have been unable to find in my county the female obstetrician, the female ophthalmologist, the female otolaryngologist and the second female general surgeon who are listed as practising with me, according to central Ontario reports, but I have not yet resorted to surreptitious surveillance of the surgeons' changeroom.

On a more serious note, these same statistics indicate that there are over 230 physicians doing family and general medicine in Essex county. Our Essex County Medical Society would estimate, with reasonable accuracy, that the maximum number of such practising physicians would be about 175. That's a number far below the recommended standard of 241. Our new county residents know this by the difficulty they experience in finding a family doctor upon arriving here. Similar difficulties are experienced by established residents who lose their existing physicians through retirement, death or, most commonly, through relocation to the United States. The faulty data used to make manpower distribution decisions from afar could create a disaster. Local physicians have always worked to lure appropriate generalists and specialists to fulfil local needs. Now that role would be totally frustrated.

I would respectfully remind the committee that other parts of Bill 26 have received praise for the transfer of powers and responsibilities to more local government. I therefore find it appalling that in the critical area of health care Bill 26 shifts incredible powers away from the

local, responsible bodies to the Ministry of Health, where there is real potential for their misuse, either inadvertent or deliberate, in the absence of local accountability.

A further concern I have is that schedule I proposes to eliminate all previous and existing government-OMA agreements. In that scenario, the government would be in clear violation of the accessibility provision of the Canada Health Act of 1984, which mandates that medical practitioners must be compensated via a process which includes negotiations with a dispute resolution mechanism. If schedule I comes to pass, what am I, as an honest Canadian, to do? Which level of law should I obey? Will I be forced to go outside an apparently illegal system? Difficult choices lie ahead.

Lastly, I would like to comment on a report which I heard on the CBC news today, and I admit it may be inaccurate, but it was indicated that there was an offer to sunset the law after four years, presumably after completion of the government's goals. I must protest the hypocrisy of this approach. If this is a good law, then it should be a good law in the hands of any government. Rather than establishing a sunset for this law, I would suggest that it not be allowed to see the dawn of day.

Dr Netherton: I'd like to continue. My largest concern as a physician basically is the castrating of the OMA. With the bill as it stands, the OMA would not be able to negotiate with the government on behalf of the doctors of Ontario. The statement, "Trust me, I'm from the government, I'm here to help you," is meant as a joke. I don't believe it, and I don't think many people across society believe it. The government cannot decree from on high where I should work, how much I should work and how much I should be paid. That is the Communist way, not a Conservative way.

I hope that doctors are finally angry enough that they will not let the government split them into many small factions to be devoured or fed to the wolves as they see fit. I'm not a negotiator and I have limited time for family and non-medical pursuits. I can't negotiate a salary with government. I think maybe it's time we have to talk to CUPE or maybe the CAW.

The government really can't believe that it can govern by decree and get the so-called best bang for the buck. This keeps going through society. In the 1950s, a doctor of mathematics actually, Dr Demming, was laughed out of America and went to Japan. There he showed that to make a strong, efficient, profitable company, the workers had to tell management what was the most efficient way to perform the job, and look what happened in Japan.

The government's biggest asset in producing a viable, effective health system is the health care workers, if they'd only listen. Sometimes they think they listen and dump an area of responsibility on them. Suddenly we are responsible for a new area, but they forget to give us any power to accomplish this. The best example is the past government and the social contract. It made doctors responsible for utilization, but they refused to give doctors any power to control utilization. Decrees from above without worker input equals a mess. Responsibility without power equals frustration. We are either partners in health care or we are adversaries in health care.

The government may have the best interests of Ontario at heart, but I don't feel that Bill 26 will work. There's too much power. Personalities, greed and human jealousies will all undermine any good intent unless safeguards are built in. After passage of the bill, the powers—we've already gotten through that, so I'll skip that if I may.

If the bill passes as is, it will really only be one more slide on the downward slope medicine continues to take. I, as a physician, can ensure that my mother will always get a CAT scan when she needs it. My children, my grandson, as well as Mike Harris's family, will always be able to see specialists when they want to. The majority of Ontario citizens, however, will have to put up with longer lineups, more rationing and outdated care.

One of my four children happens to be extremely intelligent, I think. He has always talked about going into medicine as his field until about a year or so ago. Now he doesn't talk about it any more. I think he's so intelligent that he's changed his mind. He will now find a new area to excel in. Not only are we losing existing doctors but the best new ones will never be. The sad part is I feel that the people of Ontario will continue to accept whatever government gives them for free and will never know how good medical care could have been.

Mr Marchese: Thank you for your presentation. I know there are a lot of areas to cover, and you covered quite a few. I want to ask one question on the issue of billing number restrictions. You talked about it briefly.

I recall the members of that government introducing Bill 7, which repeals the Employment Equity Act. They said it was a very draconian act, that the job quotas contained in that were abhorrent to them. What they're doing here in this area is very authoritarian, very draconian. In fact, the cabinet and the minister have the unilateral power to force a doctor to practise in a particular geographic area, to prevent physicians from practising unless they agree to perform services specified by the minister, and it imposes numerical quotas, determining how many physicians can practise in a particular geographic area.

1520

We think these matters should be settled with doctors by negotiation. What they're doing here through this is not negotiation, and it moves from a democratic process to an autocratic one. You may have commented on it, but I'm not sure whether you would like to add some more in that regard.

Dr Netherton: If I may, I agree. I feel that the problem with underutilization or doctors not being where they're needed runs to seeing responsibility without power. I would suggest that the government tell the OMA: "We have a problem. I want you to solve it. I'll give you the powers that you need to solve it." But you can't ask us to solve a problem without having the power. I think that we could do it, and a lot better than they're suggesting.

Ms Lankin: I do appreciate your presentation. I know that from time to time over the years, with various governments, there have been points of contention between the medical profession and government, but I don't believe I have ever seen the medical profession

both so angry and so demoralized as the tone of the presentations that I've heard during the course of these hearings. In part, I don't think it's helped by the government putting out propaganda like this that says, "Ten Great Things about Bill 26 that You Won't Hear from the Vested Interests." Gentlemen, I suggest they're talking about you and other presenters who are coming forward who are criticizing them as being vested interests.

One of the things I know about the medical profession is that to a large degree, particularly in hospital settings, they are patient advocates, and I want to ask you about the process of revocation of hospital privileges. We know under the bill, where a hospital closes, that there's an absolute right to revoke, and under the old legislation there's a very complex set of reasons for revocation and appeals of that. In a sense, it's to ensure that the CEO doesn't have unilateral power over hospital privileges and that doctors who speak up and who rub CEO the wrong way can't be just dismissed.

In the new legislation, under regulations, there's a provision that the minister can set out any other circumstance in regulation he wants that can be treated just like a hospital closure and in which all of the protections in the act wouldn't apply, and that he can set out by regulations what procedures would apply. I don't know what those circumstances are going to be and/or what procedures he's going to put in place. Does the OMA know? Have you been given any information? How do you feel about the fact that if you speak up, you could be next on the chopping list?

Dr Kidd: If I may be allowed to reply, I find that particular aspect of the bill frightening, as I said, even on a personal basis. It is the role of the physician to always be his patient's advocate, and sometimes that patient is a singular person and sometimes it represents a group of persons with a common problem.

One can envision through this situation that they've set up, where the hospital must provide a roster of physicians that meets the minister's approval and that there is the ability to unilaterally take away privileges when it meets the interests of the public, that the physician would be afraid to be the advocate within the hospital setting if that physician's livelihood rested with his hospital privileges.

The best example I could come up with off the top of my head would be if a new orthopaedic surgeon advocated the use of a better but more expensive prosthesis. He might advocate this to the point of making angry the bean counters in the administration office and, lo and behold, a new manpower study may show that they don't need quite as many orthopaedic surgeons as they used to and therefore the young advocate suddenly loses his privileges and his ability to practise in that hospital, and perhaps that town.

Mr Clement: Ms Lankin on occasion astounds me. When she said that doctors should be patient advocates, it was her government that instituted the Advocacy Act, as we all know. So I think we are seeing a shift in position with respect to that.

Ms Lankin: I don't think so. Mr Clement, I can speak for myself.

Mr Clement: I know you can, Frances.

Can I just get back to what I see as a fundamental dilemma that you are facing and, if I can be so bold as to

say, I as a Conservative looking at the system face as well. If you came at me and argued, as you have done, that there should be greater say of the providers in terms of utilization, push it down from the bureaucracy, push it down from government, down into the community, down into the patient-client relationship, you know what? I agree with you, although nine other presenters here today don't want to see any such radical shifts in the health care system. They like the status quo when it comes to that sort of relationship.

Mrs Papatello: That's not fair, Tony.

Mrs Caplan: That's not true. That's an unfair categorization.

The Chair: Mr Clement has the floor.

Mr Clement: I'm being provocative again. I apologize. But I guess my question to you is, that's one point of view that is a pressure on the system which is knocking us off the status quo. But there are other people—and I as a Conservative also understand this point. If I had my way, if we could run a perfect health care system without the government being involved, believe me, that would have my vote. But given that there's a consensus that the government should be involved, I as a Conservative also want to act on behalf of the taxpayer. You know, it's the taxpayer who pays your salary. It's the taxpayer who collects your bills. It's the taxpayer who ensures that the system runs, because people wanted the government involved and we represent the taxpayer. That's what government does. So how can we reconcile your point of view that we should be pushing down, you should have some control over utilization? That's what you said. How do we reconcile that with my responsibility as an elected representative to the taxpayer who pays the bills?

Dr Netherton: I think you're right; I advocate from the bottom up. If you read any of the CQI or TQM or whatever all those things are, you don't tell a worker how to do it; you ask him how to do his job efficiently.

Mrs Caplan: Exactly. Quality management.

Dr Netherton: What you've done with this bill is, it's too large. You couldn't ask the workers, you couldn't ask the bottom line to submit changes and improvements in five years. It's just too big a bill. You're trying to change too many things. The way you're going about it, I don't think you're going to be able to do what you want to do.

What you want to do is improve the system. Unfortunately, you have to take somebody's advice, and I think that somewhere along the line you've gotten bad advice.

Mr Clement: Fair point.

Mrs Papatello: I have a quick comment to make before I address your question.

Mr Clement needs to understand what city he's in today. For him to suggest for a moment that the people who presented here today are in favour of the status quo—you've got to be kidding.

These people from the city of Windsor have been looking for change for years, have been working towards change, and your government has let us down. We do not want status quo, and for you to suggest otherwise, that is just inappropriate behaviour on your part.

Mr Chair, you've got to keep these members contained in terms of their attitude as well.

In terms of you representing the taxpayer, you had 37,000 people at Queen's Park on Saturday. Those are all taxpaying people. Does that mean you're going to reinstate the \$400 million you've lobbied from education? I don't think so.

Mr Clement: Do you have a question for the presenter?

Mrs Pupatello: I certainly do.

Mr Clement: If you want to carry on a debate, we'll do it afterwards.

Mrs Pupatello: The point is that you are representing taxpayers and these are taxpayers. Just remember who really are the taxpayers here.

I'd like to ask a question for those who presented, very quickly. We're concerned that you're going to have potentially the minister's ability to just shut down the radiologists' facilities. There's another way to close you down, and that is by changing the levels of payment, because the bill also allows for the minister, with no medical support, to make decisions that determine what fees should be paid. So you'll have death by a thousand cuts: You'll just continually get paid less and less for the various services, so it'll just run you out of business and allow the Americans to set up posts here, which is a quiet way to put you out as opposed to shutting you down. I submit that this government has been, above all, brilliant in political strategy, and that is where you're going to see the changes coming. It's going to be that death by a thousand cuts, because they'll implement their own social justice and morality by changing levels of service. That was pointed out to us yesterday as well. Do you have a comment?

Dr Netherton: I have a quick comment. I think medicine has been dying the death of a thousand cuts since I got into it about 30 years ago. This is just accelerating the procedure. I agree, but I they could have shut X-ray offices down for many reasons at any time with the existing legislation and the rules they have. They don't need more.

The Chair: Thank you very much. We appreciate your presentation and your interest in our process.

1530

ESSEX COUNTY MEDICAL SOCIETY

The Chair: The next group is the Essex County Medical Society, represented by Dr Ian McLeod.

Dr Albert Schumacher: Mr Chairman, ladies and gentlemen, thank you for giving us the opportunity to present to this committee on behalf of our colleagues, the members of the Essex County Medical Society, and our patients, the residents of Essex county.

I'm a general practitioner in Windsor, a member of the society, as well as a member of the board of directors of the Ontario Medical Association. With me is Dr Ian McLeod, president of the Essex County Medical Society.

For the past seven weeks we have been intensively studying the proposed legislation, with great difficulty, due to its scope and severity. Its effects are far-reaching and, we believe, extremely detrimental to the health care system we have helped to build in Ontario. I'll ask Dr McLeod to address his concerns before making some recommendations.

Dr Ian McLeod: The very first thing I'd like to open with is to say that I do represent a special-interest group. Do you know what that interest group is? The people of Essex county. I have some prepared remarks and I have some extemporaneous remarks I want to make.

I wrote an article for the Windsor Star and I'd like to read it into these minutes, if I may.

"On November 29, 1995, when Bill 26 was introduced, few of us could have envisioned the depth and breadth of the changes proposed. If passed, the bill will vest the government with unconstrained powers, allowing them to rule by decree, often without opportunity for public scrutiny, debate or even input from the community or local stakeholders.

"This is being done under the banner of fiscal responsibility and more efficient government, but is inherently dangerous since these powers are broadly granted without conditions traditionally provided to ensure political accountability and effective recourse through the courts.

"From the medical perspective, it is lamentable that their solution, in addressing real health care delivery problems, damages what is good in the system. The astonishing new controls proposed over physician mobility, remuneration and practice patterns will adversely affect patient care."

Some examples, if I may. I've got to tell you that there may be some repetition here, but it's because we all arrived at the same conclusion in our own different ways.

"Physicians could be asked to personally pay for the cost of medical tests and specialist consultations, if some bureaucrat deems specific care to have been medically unnecessary." I asked the people of Essex county: "What will that do to your 'complete' physical and preventive disease management such as mammography? What if you want another medical opinion?"

This moves us back decades to a time when the cost of a test could be more important than the patient's needs. Our system is the envy of the world, where doctors can take care of patients, thinking only of these needs. I think the people of Ontario would find it offensive that anyone would be personally responsible for the cost of medical tests under the guise of being medically necessary.

My first question is, what is the definition of "medically necessary"? Is it the preservation of life? I would think so. Is it the prevention or detecting of disease? I would hope so. But what if it's done just to relieve anxiety, to offer reassurance? Medicine is not just a science, it's an art. It's called the healing art.

What about that terrified 35-year-old female who comes into my office? She perceives a breast lump. I may not agree. I try to give her my reassurance, but I look in her eyes and I see the terror; her mother may have had breast cancer. And I do what I'm supposed to do—I practise the healing art. The healing art in this case means ordering the mammogram, and although it may be deemed medically unnecessary in the sense of some plugging in of a scientific formula, it is part of medicine. We deal with patients in a holistic manner. It isn't just an organ I deal with; it's the person with that organ. And damn it, as long as I am a physician, I am going to treat people in a holistic manner and I am going to order that mammogram.

"It is proposed that no new physicians be allowed to set up medical practice in a 'well-serviced' area. (Historically, Essex county has been incorrectly labelled well-serviced.)" It's been pointed out that there's potential here that no new physicians may come.

Fleshing out Art Kidd's speech, we appear to have three neurosurgeons on that list. In reality there are only two. That female obstetrician he couldn't find; she left four or five years ago from the Leamington area. It's my opinion that having been dealt with in the past as a well-serviced area, and with my perception that this government doesn't listen, there is a grave danger that this false impression will be continued.

"Malpractice copayments are to be cancelled. This tradition was started about a decade ago instead of a pay raise." Do the people of Essex county know "that the income generated from the first 120 babies delivered will just go to pay an obstetrician's malpractice insurance? Most rural obstetricians only deliver about 120 babies per year, rural family doctors even less. The implications are obvious."

When I started medicine in 1974, the malpractice insurance for family physicians and specialists was \$50 per year. By 1986, an obstetrician was paying \$4,900 per year. This year, he will be asked to pay \$23,340 per year. When I started delivering babies, I got a little under \$200 in the mid-1970s. Now the fee is \$240-odd. It doesn't keep pace with the times, does it?

What about an orthopaedic surgeon? He will be asked to pay \$22,440; a neurosurgeon the same. We're small business people. We have to ask ourselves, can we afford to offer the service? What a terrible position to be put in, to decide whether you can afford to offer a service. This is not why we came into medicine.

"Hospital-based physicians (surgeons, anaesthetists) could lose hospital privileges without reason being given or legal recourse."

Again, this has been given very vocal and clear direction by Dr Arthur Kidd ahead of me. I could only re-emphasize one or two things. By putting a specialist in a position where he may lose his ability to earn income and feels threatened by an administration forced to balance budgets, there is a double whammy. It is proposed in this bill that billing numbers for specialists be tied to hospital privileges or institutional privileges. In other words, the possibility exists that a specialist may be unable to practise medicine, particularly if he makes too much noise. Ladies and gentlemen, welcome to the feudal system of the 20th century. This is a 13th-century, medieval mentality.

"User fees on senior citizens for their drug use. This is one area where economic issues must be tempered with compassion. No Ontario citizens on fixed incomes should be forced to decide if they can afford medication."

1540

This bill states that if you earn \$16,000 a year, you pay \$2 for a prescription, and \$2 and \$2 and \$2 and \$2, and it will all add up. Should we be putting people in a position where they may have to make a choice between rent, medication and food, even if it is tuna? There's another level here too. What about that group of people, low-income, perhaps working part-time, no benefits, no

drug plan? What a wonderful time to bring in the deregulation of drug costs. Thank you very much.

I'm not done. That comment was directed towards the government.

"Disclosure of confidential medical information." This has been well worked over by previous people, but I'd like to point out a couple of facts. First, the government has stated it needs this in the bill so it can monitor physicians to make sure there's an appropriateness between billing and service rendered. Well, I humbly submit that there are plenty of long-standing regulations in place between the College of Physicians and Surgeons and the monitoring agencies of OHIP to deal with this. If that was the major reason, why did they slide in that other little phrase, "and for release of information for any other purpose prescribed by cabinet." Wow. Where will that lead us all?

Lastly, one that really, really concerns me is taking our fee schedule away from the OMA. Traditionally, the pot has been set up so that we internally decide what a hip is worth, what a cataract is worth. The minister will be empowered to dip into the schedule. This probably doesn't sound like much, but's going to allow him to use the schedule as a tool for social policy. Think about this. If some government, maybe not this one, feels there's not enough access to abortion, he could increase the fee. If, conversely, he felt there was too much access to abortion, he could reduce the fee to zero. I'm not taking one side or another on this issue. It's a very controversial issue. What I'm saying is, should any minister, any government, be given this type of power?

"The above is only a partial list of my concerns regarding Bill 26 and its effect on patient care.... Suffice it to say, if passed in its present form, this bill decertifies our 'union,' the Ontario Medical Association, by taking away representation rights, cancels contracts, eliminates grievance procedures, allows termination of employment without giving cause and bans legal recourse."

Would the CAW put up with this with the Big Three?

"It is a black day when any government elects to fracture the traditional agreement processes between patient, doctor and government in the management of health care and elects to go it alone.

"Mike Harris has sadly forgotten that evolution is healthier than revolution," and has given a whole new meaning to the term "code blue." Thank you for allowing me to present our case.

Dr Schumacher: In response to the call from the opposition this morning for someone to do work on recommendations and amendments, we've put a little head time into this. I'm going to give a little preamble, and I'll make specific reference to schedule I. The medical association in the past has been able to negotiate agreements with all sorts of governments. In fact, we negotiated not less than five agreements with the NDP, and as difficult as that was, we managed to do it. We have been trying to do that with this government and have been unsuccessful.

There are five pieces of legislation that will be affected by the Physician Services Delivery Management Act, schedule I. These include the 1991 OMA-government framework agreement of April 1991, the 1993 OMA-

government interim agreement and the physician sectoral agreement of August 1993.

As a result of these agreements, physicians have helped to decrease OHIP utilization from the double-digit range of the late 1980s to the 3% range per year. Three factors that raise these costs and that continue to go on must be kept in mind.

The first is that the population of Ontario increases by 1% every year, mostly through immigration. It is not my colleagues and I having these children; they're put upon us. And they're usually not children; they happen to be adults and they have their share of health problems. The second is the increase in availability of new technology, such as MRI scanners, mammography, bone density scanners and laparoscopic technology, which again accounts for an increase of 1% a year. The third is our aging population, which again accounts for a 1% increase per year.

Physicians have lived up to their obligations in paying for this, including the clawback which currently runs at 10% of our billings.

The government has unfilled obligations, which have been successfully appealed and subject to orders by the referee of agreements to give back to the OHIP pool \$30 million, plus \$1 million a month, for just one of the ongoing violations.

The government wishes to rid itself of its obligations while keeping the bad parts. It does not even wish to live up to court awards to the generic drug manufacturers. Are the bondholders going to be the next told that the government will not live up to its financial obligations?

The OMA does not believe that any group in society is prepared to exist totally at the whim of the government and to have no ability to represent itself to the government and be recognized. Agreements which are entered into in good faith should be respected.

We urge the government to continue to recognize the OMA as representative of Ontario physicians. We believe that the government should be willing to enter into agreements and to honour and abide by them.

Speaking now on behalf of the president and the board of directors of the Ontario Medical Association, I recommend the following amendment to schedule I. This does not in any way imply endorsement of schedule I or any other aspects of Bill 26.

The recommendation is to replace all of the current wording with wording that would incorporate the following principle:

We would like to see the existing agreements in subparagraphs 1(2)1i, ii, iii and iv of the schedule to be terminated only upon negotiation and execution of a new agreement by the OMA and by the government of Ontario which would replace the said agreements.

We continue to work intensively and will be presenting other amendments to this committee at other opportunities, albeit limited, during the coming week.

Mrs Ecker: Thank you very much, doctors, for taking the time to come forward today and bring forward some suggestions. If I understand you correctly, you have some concerns about the OHIP general manager's powers to make a decision about "medically necessary."

Dr Schumacher: That's right. That's absolutely correct.

Mrs Ecker: How is it done now under the Health Insurance Act?

Dr Schumacher: Medically necessary services have been largely unchanged under the act and the fee schedule for many years. They came up to a review. In fact, there was a delisting panel that looked at a number of recommendations during the last government which removed a small number of services, probably to the tune of about \$12 million.

Mrs Ecker: I'm not taking about the delisting exercise. I'm talking about the general manager of OHIP deciding what's medically necessary in terms of payments.

Dr Schumacher: Currently the general manager of OHIP does not have a purview to decide what is and what isn't medically necessary.

Mrs Ecker: Well, it says here in the Health Insurance Act, "General Manager...all or part of such services were not medically necessary." There is that "medically necessary" phrase in the new legislation. You can make an argument that the general manager shall refer the matter to the Medical Review Committee at the college, which you've mentioned, to determine medical necessity, but the college has told us that the Medical Review Committee as currently structured is not working. They have suggested that we need to look at some changes and to try and streamline and make that process better so that it can go after difficulties.

If we were to streamline the Medical Review Committee in some fashion so that we don't get physicians tangled up there for two, three, four and five years, would that help to address some of the concerns that you've talked about with the general manager?

Dr McLeod: In terms of a philosophical point of view, we have no problems with peer review, and that is the bottom line. But we want it to be a peer review.

Mrs Ecker: Okay. Do you support the activities of organizations such as ICES?

Dr McLeod: Absolutely.

Mrs Ecker: How would you advise the ministry to share health information with organizations like ICES to do the good work they do without the minister having the power to make agreements to disclose information?

Dr Schumacher: I believe that since its inception by the last government and the OMA, ICES has gotten off to a good start and has been working very well, and I believe that the results that have come forward already, the ankle study, the hypertension guidelines and other things that have been put forward, have been done independent of the current government.

1550

Mrs Ecker: There is also some power of agreement for previous ministers under the Health Insurance Act to collect, use and disclose personal information. But as I understand it from people who are in the field who want to expand the ability of the system to manage better, to do more outcome measurement, we have to make sure that we're collecting it from all the facilities out there that are providing health care. The experts tell us we need to do that, and I guess the question is, how do we

do that and have that information available to make better clinical outcomes and judgements without sharing or having access to information in some manner?

Dr McLeod: There is no argument that there are areas for improvement in the science of medicine, and we would all agree there are clinical guidelines that have to be put in place, when to order thyroid, blood tests and so on. What I'm trying to bring out in my presentation is that there is more to medicine than just simply the science—

Mrs Ecker: I'm well aware of that, very much so.

Dr McLeod: —and that there is a danger of being penalized for practising the art of medicine.

Mrs Ecker: It's certainly not the intention to penalize you for doing that.

Mrs Papatello: I just wanted to put on record that Mrs Ecker's comments give the impression that the College of Physicians is being supportive of this legislation and using managers—

Mrs Ecker: That's not what I said, Mrs Papatello.

Mrs Papatello: It certainly is, and I think it's incumbent on you—

Mrs Ecker: Quote me accurately, please.

The Chair: Mrs Ecker.

Mrs Papatello: I don't want her cutting into my time either, Chair. Anyway, it's inappropriate for you to suggest or try to trip up people who are speaking here as if the college in fact is supportive. They are not, and it's inappropriate on your part to do so.

Mrs Ecker: I did not say that.

The Chair: Mrs Ecker.

Mrs Papatello: Secondly, I'd like to ask a specific question. Are we underserved in terms of doctors' services here? And give me a brief on the history of doctors leaving this area—let's just pick the last five years—and what you expect will happen when this bill is passed on the 29.

Dr McLeod: Before this bill even became part of the landscape, there were approximately 25 physicians who left this county over the last five years, probably—would you say a 60-40 split?—

Dr Schumacher: Correct.

Dr McLeod: —specialists to family physicians.

The political climate has worsened. I cannot support this in fact but I have heard through my colleague that a large percentage of the graduating class at the University of Toronto is seriously considering going south and that figures of 75% to 80% have been banded around within our milieu.

It certainly will not improve the likelihood of keeping people here, but I will also say to you that, in talking to a number of my colleagues, they want to stay for now to fight the good fight because we are members of Ontario. We feel that we've got a good system. We feel that we can maintain this system and improve it. If we all work together through negotiation, through settlement, through cooperation, perhaps we can come out at the other end with a decent system.

Mr Crozier: Thank you, doctors, for taking your time to come to us today. I want to bring up the point about the privatization. There is in the act, as I'm sure you're well aware, certain indemnity for the minister, for the

director and inspector and assessor. Everybody seems to be indemnified in this act except for the practitioner.

Is that a concern of yours, that notwithstanding that this act may go through as it is and that certain information may be made available to the government that we are not comfortable with, that still doesn't prevent someone from taking it to court and suing you? With that thought in mind, may it also, in your opinion, encourage some practitioners not to include all the information on a chart that you normally would; in other words, frighten them from really recording the information that you normally would? Can you give me some sense of that, how you feel about that?

Dr Schumacher: I think I can answer that question for you. We already have fear from patients who come into our office, and they ask us outright, "Will this information be recorded?" and can we possibly not include it in the chart. We have an increase in off-the-record applications, so to speak, for advice, whether it be about their family, their family's history of mental illness, their own concerns about mental illness, sexually transmitted disease. There's a whole gamut of things that go on our in offices which have no business outside our offices.

Yes, I think you will see more. You will go back to the days of smaller and smaller charts, back to the days of my grandfather when the entire medical record was kept on a cue card. It's very difficult to transmit and to keep up a decent record, to let one's colleagues know what's going on, but you're going to go back to one-word consultations.

Ms Lankin: I listened carefully to Mrs Ecker's questions and while she did not specifically state that the general manager under the previous plan could determine medical necessity—

Mrs Caplan: She implied that, absolutely.

Ms Lankin: —you have to say that the questions might have given that perception to some of the people listening, because it was the perception that I had of what she was intending.

I just want to make it very clear that under the old act the words were very, very clear that "where...it appears to the General Manager on reasonable grounds that...all or part of such services were not medically necessary," he "shall refer the matter to the Medical Review Committee," who will make that determination and the recommendation back. Of course, in the new act, the Medical Review Committee is cut out unless the physician takes extraordinary acts of appeal up to that process. It's the general manager, ie, someone in OHIP and not necessarily a professional or a doctor or a peer review, who would be making that determination.

Now, in order to make that determination, I would think first of all you have to have the professional qualifications, so let's put that aside. The government has argued it needs access to patients' records in order to get at the issue of fraud and that this all comes together with the general manager being able to send his inspectors in and take the files out of your offices and determine whether or not you have defrauded the OHIP system.

Just now we heard Mrs Ecker say we actually need to disclose the information in those patient files so that ICES, the Institute for Clinical Evaluative Sciences, can

do its epidemiological work in the development of clinical guidelines. My recollection of that, having been somewhat involved in the establishment of it, is that they don't need to go into patients' records to do their work. In fact, within OHIP already there is the ability from doctors' billings to look at the number of procedures billed in any geographic area, compared to other geographic areas, and to sit down and peer review with physicians. When you find out that in eastern Ontario they're performing more C-section births than vaginal births, you sit down and you talk about why and what are the practice decisions that are being made. Through that process, you develop clinical guidelines which you then share and you have peer influence.

Why would David Naylor or anyone else at ICES need to go into a patient's file to determine what the epidemiological support is for the development of the clinical guidelines of practice?

Dr Schumacher: You're quite correct. Currently, they have more HMRI data that they've used and still have to use to keep them busy probably for several months or years.

Ms Lankin: That's the hospital management records information.

Dr Schumacher: That's correct. It's clean of any personal information. It's certainly managed and supervised by professionals in that area, and from what we can see since we established ICES, we can't see any major leaks yet.

Ms Lankin: Here's one of the problems I have and it was my frustration this morning around the amendment. We keep being told the government is going to amend the privacy area because of all of the concerns, and yet they keep sitting here and defending the reasons for these changes. We don't know what the amendments are. If they would table the amendments we could determine if they've taken the privacy commissioner's advice and we wouldn't have to waste our time talking on that issue any more. We could go on to other areas. Let me just ask—

The Chair: Thank you, Ms Lankin. Thank you, doctors. We appreciate your interest in our process and your presentation today.

WINDSOR AREA CAW RETIRED WORKER COUNCIL

The Chair: Our next presenters are the Canadian Auto Workers retirees, represented by George Johnson, who is the chair, and Les Batterson, who is past chair.

Good afternoon, gentlemen. Welcome to our committee. You have a half hour of our time to use as you see fit. Questions would begin with the Liberals, should you allow time for them. The floor is yours.

1600

Mr George Johnson: My name is George Johnson, and I'm the chairperson of the CAW retirees and seniors. We represent some 45,000 CAW retirees and seniors. We also believe we are speaking on behalf of some of the seniors and retirees who couldn't make it to the table today. We want to present our views to this committee and our concerns.

Until the government has had time to develop a coherent strategic approach to the transformation of

public services, is the only instrument available a meat cleaver? The Common Sense Revolution reference to health care clearly states, "We will not cut health care spending." Under "Fair Share Health Care," it clearly states, "Under this plan there will be no user fees." Were these promises earmarked to catch the voters' attention and, if elected, to weasel out of? We sincerely hope not.

Physician-prescribed medication is clearly a part of health care to seniors. Statistically, under schedule G, 86% of persons over 65 are affected by disease in one form or another. One of the major concomitants of growing old is susceptibility to one or more chronic illnesses such as heart condition, strokes, arthritis, hearing impairment, high blood pressure and diabetes. Unlike an automobile, where parts can be replaced when worn out, when human organs begin to wear out, they often must be maintained with drugs. Imposing copayments under Bill 26 will mean that patients living in or near poverty will face financial barriers to getting the medication they need.

Our recommendation is that you raise the minimum income levels of \$16,000 and \$24,000 to \$35,000 to \$40,000 annually. We want to stress to this committee and to the government, to set the record straight, that we do not believe in user fees at all, by any name. But if you are insistent on introducing them, do not apply them to people who have to decide whether to fill the prescription or eat, knowing they cannot afford to do both.

Second, we submit that the use of generic drugs will lower costs to the drug plan substantially. Your government should implement legislation which states that generic drugs must be used in all cases where the physician and pharmacist recognize it as adequate to do the job for that particular patient. Physicians are not opposed to prescribing generic drugs if they are of high quality and comparable to the original drug. The federal government, as of September 1, 1995, implemented a generic substitution plan for all its employees, saving the government millions of dollars in drug costs. A similar plan has been introduced in British Columbia.

Third, your proposal to deregulate drug prices in Ontario seems to be contrary to your cost-cutting ideology and is a nonsensical exercise, given the needless additional cost this would inflict on Ontarians as well as on your government. There is no question that drug prices would immediately increase, creating more costs to the drug benefit plan. We recommend deletion of this proposal.

Fourth, many older citizens suffer from several diseases and may visit more than one physician. It then becomes very possible for them to suffer from physician- or self-induced problems as a result of overmedication or an incompatible combination of medications that interact or produce unfavourable reactions. This costs the system needlessly, both in terms of drug costs and hospital costs. We recommend that the ministry concentrate on developing better mechanisms for physician tracking of their patients' medications; for example, that the family doctor prescribes all medication in consultation with any specialist a patient may be receiving treatment from. Further, your government would be wise to expand drug awareness programs like the one established by the Canadian

Auto Workers to train seniors to be aware of the dangers of overmedication and to take charge of their own bodies.

Prior to any funding cuts to hospitals, the Ministry of Health should consult with the citizens who will be affected by such a move, especially through the local district health council. The ministry should not have the unilateral right to determine what is in the public interest.

The patient and appropriate health care providers should be the only ones to have access to any patient's personal health records. To send in government inspectors to probe patients' medical records is a direct violation of the Ontario information and privacy act. Notwithstanding the disclaimer in the bill, should this type of information get into the wrong hands—and it would—it would be harmful to the patient. For whatever reason, can you justify invading the privacy of the citizens of Ontario?

The French government has arbitrarily decided to deny or severely restrict access to dialysis treatment for patients over 65. Further, no one that age or older is considered for a bypass operation.

You have included in Bill 26 provisions for the Minister of Health to unilaterally determine what constitutes unnecessary services and deny paying doctors for services rendered. We are aware that there are demanding patients out there, but this responsibility does not belong to the Minister of Health or his bureaucrats, and if implemented as recommended in Bill 26 will only serve to undermine the confidence the citizens of Ontario have in our present health system.

We recommend that the Ontario Medical Association be mandated to establish standards, guidelines and regulations for the provision of health care services in conjunction with the Ministry of Health and then be responsible for their enforcement among its members.

The ministry has already implemented limited access to home oxygen for patients. We would like to cite two cases we are aware of to illustrate the profound hardship this new regulation has imposed upon individuals. I've been asked not to name the individuals, but I will give you their case histories. This is from a daughter about her mother.

"My mother is 78 years old and is in the advanced stages of a disease called pulmonary fibrosis. This is a horrendous disease in which you eventually suffocate to death due to the lining of the lungs becoming hardened, forming cysts and tumours within them. There is no treatment available and her only comfort is the 24-hours-a-day oxygen she receives from her concentrator in the large portable tank in case the hydro was turned off.

"I am appalled by your government's decision to allow her to be denied funding due to your guidelines that she requires oxygen only during exertion. Does this mean she will have to spend the rest of her life lying in bed so as not to exert herself? Her movements are so limited now that I can't imagine what will happen to her. It is absolutely unthinkable to say she does not meet your criteria. It will be \$345 a month for her to rent the concentrator and the large portable tank will cost her \$215. She lives on old age security and CPP, which is less than \$1,000. How could she possibly pay for this oxygen?"

Second, this gentleman is 44 years of age. He has pulmonary fibrosis, interstitial lung disease, has lost 65%

of his lung function, is diabetic, has severe angina, one kidney functioning, and not too well. He's an epileptic. He was told that his oxygen will be cut off. He has only \$1,360 a month and he would have to pay \$250 a month for his oxygen requirements. His doctor says that if he cannot afford it, he will have to hospitalize him, at \$452 per day. Where is the rationale?

These cases are examples of the hardships created by even the smallest changes in the health system, and they are indicative of the necessity of using extreme care and caution in moulding reforms. The system did not become faulty overnight and quick and dirty resolutions will not satisfactory solutions.

We trust that the minister will take a serious look at our remarks today with respect to the ramifications of the proposed Bill 26 and its effects on the seniors and retirees of Ontario and other people of similar circumstances who are unable to present their case before you today.

1610

Mr Les Batterson: Mr Chairman and committee members, I appreciate the opportunity to appear before you. As George pointed out, I am the vice-chair of the Windsor Area CAW Retired Worker Council.

My colleague George has outlined many of our concerns with regard to the health care section of Bill 26, and you have heard similar and other concerns from a broad cross-section of people across Ontario.

Since our medicare program is supported by a large majority of people in Ontario and Canada, I would first like to outline its beginning. I am old enough to remember when people did not get needed health care or went broke trying to pay for it. It was initiated in the Ford strike of 1945 and consolidated in the 1954-55 strike. We were also fortunate to have progressive doctors in Windsor who established Windsor Medical Services, which we incorporated into our program. The success of this program brought about Physician Services Inc in other parts of the province and made pre-paid health services available to many in Ontario.

Tommy Douglas legislated health care in Saskatchewan and it spread across Canada. We worked to bring health care to all the people of Ontario and our program became part of the Ontario health insurance plan. Hopefully, if we know history, we won't repeat it. With a long history of having adequate, affordable health care, it is obvious why we are concerned about the passage of this omnibus bill without adequate time to study and amend it.

My second item is the matter of a mandate. Regardless of unofficial polls, the election is authentic. Mike Harris received 45% of the vote, but when coupled with the high percentage who didn't vote, it means that 55%-plus, a majority, did not vote for him. Surely this must be considered. Also, Bill 26 was not discussed during the election and possibly would have made a change in the results.

My third item troubles me as a veteran and this being the end of the 50th anniversary of the Second World War. In 1934, Adolf Hitler put through legislation that negated the German Parliament. It surely doesn't seem the appropriate time to pass this omnibus bill, which would have much the same effect on our provincial Legislature.

We believe that the Ontario voters believe they were electing legislative members who would openly deal with the governing of all of Ontario in the provincial Legislature. From your hearings it is obvious that this unwieldy omnibus bill, particularly the health care sections, needs more study and reworking before it is passed. January 29 is too soon. We urge members of provincial Parliament, of all parties, in the best interests of the people of Ontario, to make this happen.

We once had what we think they're trying to give us back. We had private health care back when we established the first programs. It didn't work then, it isn't going to work now, and it isn't working in the United States.

Mr Crozier: Thank you gentlemen. I applaud you. You're seniors who could sit back and say, "I'm retired; I'll live out my years comfortably and not complain about this," but I think you also see that you may not live out your years comfortably if you don't complain about it.

In any event, I want to see if I understand something and if you understand it the same way. The government has made it a solemn promise that they will not cut one cent out of health care. We know they will be taking \$1.3 billion and applying it to the deficit. It's their own figures.

Mr Johnson: That's not one cent.

Mr Crozier: That's not one cent; you're right. If they were to spend \$17.4 billion for four years, that would be almost \$70 billion they'd spend on health care. But if they spend \$1.3 billion less for those four years, they're only going to spend about \$64 billion. Now is my math wrong or do you think that over that period of time, at \$1.3 billion a year, they're breaking a promise not to take one red cent from health care?

Mr Johnson: I definitely agree. I think if you go back a decade ago, we were spending \$70 billion on health care, if I'm right. So it hasn't changed a lot. So to take \$1.3 billion out of health care, something has to be taken out from giving to the people of Ontario.

Mr Crozier: So you and I aren't going to be fooled—

Mr Johnson: No.

Mr Crozier: —if at the end of the period of time we look back and they spend less than \$69.6 billion, are we?

Mr Johnson: No.

Mr Crozier: Do you know that of this money that's going to be given back in a tax cut they're going to borrow every cent of that?

Mr Johnson: No.

Mr Crozier: Because at the end of the term of this government—in fact they're saying now they won't be able to balance the budget as soon as they thought—the deficit will increase from around \$100 billion to \$120 billion. So they're not fooling us there either, are they, when they have to go out and borrow the money to give back to those who can afford it better than you and I?

Mr Batterson: Unfortunately, they're playing with the wrong problem.

Mr Crozier: Would you like to help them with what problem they should be playing with?

Mr Johnson: I think one thing is that it's going to eventually get worse because the last unemployment figures have shown that jobs in Ontario have not increased, and the only place that you get revenue is from

people working. So if the job market is down and it keeps decreasing, your revenue is going to fall. So where are they going to get their revenue to put this 30% tax—he might be a P.T. Barnum—

Mr Crozier: Well, they're going to borrow it, sir.

Mr Johnson: There's a sucker born every minute.

Interjection: Through job creation.

Mr Johnson: Yes, well, they've only created 17,000 jobs in the last three months. So—

Interjections.

Mr Johnson: But they're going to borrow it. So if they borrow it there's going to be an extra cost for borrowing the money, right?

Mr Crozier: Certainly, \$5 billion. So wouldn't you, rather than borrow the money for that tax cut, take a closer look at what they're doing to health care and to what it's going to do to your future health care?

Mr Johnson: Yes, absolutely.

Mr Crozier: The point I'm trying to make, though: There are different ways to get at the same problem. We all want to reduce the annual deficit. We all want to eventually eliminate the debt.

Mr Johnson: But don't do it on the backs of the retirees and the sick and the underprivileged.

Mr Crozier: He has said it better than I, Mr Chair.

Ms Lankin: I couldn't agree with you more and I do believe there are alternatives that could be pursued. But I want to touch on a couple of points you raised which I think go to the issue of universality of medicare and the preservation of our medicare system. A couple of these points are technical and I just want to set up my argument for you.

I believe earlier, and I'm sure Ms Ecker will correct me if I'm wrong, but there was a presentation that talked about the change in the definition of insured services, and the person was worried about deletion of the reference to medical necessity. Ms Ecker had pointed out that in the new act under 11.2 in fact the reference to medical necessity was there: prescribed services that are deemed medically necessary. In fact, it was Ms Ecker, because I immediately piped up and said, "Yes, prescribed," and I provoked her, and I shouldn't have interjected, but she came back at me and said, "Yes, and it was prescribed in the old act too."

1620

Well, as I am prone to do, I'd like to correct the record. I just want to point out that in the old act under the definition of insured services, those services in health care facilities or hospitals such as set out in regulations and prescribed were insured services, and then all services rendered by physicians that are medically necessary were insured services, and then other health care services rendered by practitioners under conditions set out and prescribed.

It used to be that all medically necessary services by doctors by the legislation were deemed insured. In order for something to be uninsured, unlisted, there was a process to go through with a panel looking at it and determining whether it was no longer medically necessary. I'll give you a good example of something that was delisted. I'm not arguing that that's the right strategy in health care, but something that was delisted. Other than in situations of prisoners of war camps who had tattoos,

removals of tattoos were determined not to be medically necessary—but by a process—and those were delisted. There was a process. Now it's what's deemed by the minister and set out, and I find that a troubling shift in terms of the decision-making process.

You mentioned the process of determining services by age. Under the old act, and I have said very clearly, it was under the rules of the Canada Health Act. It's now been moved. The government may choose not to take on the federal government and have a war around money, but before they couldn't do it around services by age, because the Ontario law said "under the Canada Health Act"; now they can.

There's a lot of talk about core services, the Oregon model, determining what's going to be paid for, what's not going to be paid for. I fear this is a complete undermining of medicare and a shift in values of universality, moving things out to the for-profit sector, and we see the ability of American companies to come in. You're pioneers of our medicare system, and I'd like you to comment on that and reflect on that. It's important from the values of our community.

Mr Johnson: I don't think at any time we ever questioned whether it was necessary or not, the medicare. If you needed it, the doctor prescribed it. I can look at myself, for instance. I suffer from arterial fibrillation, and it's controlled by medication. Once a year I have to go for an echo-sound and I have to go for a treadmill test. Now, each year there's no change. So what the present minister is saying is, "If there's no change, then this is not necessary any more, so you're not going to get it." That's the point that really is bothersome to many seniors. It's preventive. I could play the devil's advocate and ask, how many scans were positive that were taken? So are you going to go back and because they're all positive we're going to charge everybody? Because they were all positive, they weren't necessary? I don't think we should get into that type of a program, because it's going to undermine the whole medicare system.

Mrs Johns: Thank you very much for your presentation. Your recommendation about the substitution for generic drugs is part of Bill 26. That's part of what we're talking about doing in Bill 26, so I appreciate you bringing that up.

The other thing I just wanted to bring to your attention before I ask a question was that local input and planning is something we believe is very important to hospital restructuring and health care restructuring, and it's not something that we intend to do without a lot of consultation with the people of the community.

I have a story about a specific individual, just as you did, and this specific individual is my mother, who is 76 years old, a senior, one of the people you're representing today. In 1994, she needed valve surgery and couldn't get into the hospital. As a result she was left at home with my father, who was deaf, and they lived very far from a hospital. We were very worried about them.

To me, the system wasn't working in 1994, it wasn't working probably before that, and it's not working today. I believe that there have to be changes so that seniors don't have to wait that kind of time for heart surgery, valve surgery, pacemakers; that things have to be done to

change the way the system works. Can you comment on that for me?

Mr Batterson: No way. I have a pacemaker. When I needed the pacemaker, the doctor said, "You need this." He told me in the morning and they put it in in the afternoon. I had no waiting. I also want to point out, when my wife needed surgery—maybe we're better off down here in Windsor, because we've looked after our health care system.

Mrs Johns: You must be.

Mr Batterson: I'm very proud of what we've been able to do in the city of Windsor. I might point out it's only because we've had the complete cooperation of the doctors as we worked through from Windsor Medical into the OHIP program. We have had very few problems.

Mrs Johns: So there's no waiting for heart surgery.

Mr Batterson: There are some people, yes, but, unfortunately, it's one of those things that I guess if there's too many people, you have to wait your turn.

Mrs Johns: So you don't think there should be allocation of dollars to be able to get people into heart surgery quicker if they're waiting?

Mr Batterson: Certainly, if there were other places where they can be moved to, we hope that's part of the system.

Mrs Johns: I believe that's what we're trying to do with this bill: to manage the health care more effectively and move resources, scarce resources which are dollars to the areas that we need to have them in.

Interruption.

The Chair: Come on, folks. These gentlemen have some interesting answers. I'd love to hear them.

Mr Batterson: I'd just like to close on one thing. One little problem nobody discusses is, I was recently at a Canadian Labour Congress conference and the chairman of that conference pointed out that he'd done a study on the five years that we had unemployment less than 5%. We had balanced budgets. That's something maybe you should be looking at.

The Chair: Thank you, gentlemen. We appreciate you coming and making your presentation to us.

Ms Lankin: Mr Chair, I'd like to place a couple of questions on the record. I was wondering if the Ministry of Health would provide the committee members with information about how the cardiac surgery registry works; and if in fact a physician recommends that a cardiac surgery patient is of an urgent nature, what the turnaround time is on that. It's my last recollection that it was done within three weeks or less. If it's elective, then that's the doctor's determination.

Secondly, I was wondering if the Ministry of Health could inform us how taking \$1.3 billion out of the hospital system is going to help Ms Johns's situation with respect to her concern about waiting lists for cardiac care surgery.

HEALTH SYSTEM LABOUR ADVISORY COMMITTEE

The Chair: Our next presenters are Valerie Walter and Pierina DeBellis from the Health System Labour Advisory Committee. Welcome to our committee.

Ms Pierina DeBellis: Good afternoon. I'm Pierina DeBellis. I'm co-chair of the LAC. Next to me is Valerie Walter.

On behalf of the Health System Labour Advisory Committee, I would like to thank the standing committee for hearing our presentation today. However, I would be remiss if I did not point out our dismay at the government's attempt to ram this huge bill through with little time, almost no consultation. Given the scope of the document and its ramifications to the people of Ontario, it is inconceivable that Mr Harris could possibly feel that democracy has been served with three short weeks of hearings. With the one slotted position today at 11:30, I feel it's quite appalling that that spot wasn't filled. There are over 100 people who asked to be heard, and that spot should have been filled.

I therefore would like to join the recommendations of those before me who have urged this government to commit to a true consultation process, probably six months, wherein the voices of all could be heard and not just a chosen few.

The Health System Labour Advisory Committee was formed during the initial planning stages of the Essex county health system reconfiguration project being directed by the district health council. At that time, there existed a recognized need to provide labour's input into various aspects of health care reform contemplated under the project, and our positive role in assisting in the development of what was to become the Win/Win report is well documented.

1630

Currently, representation on the LAC includes hospital, community and consumer representatives, and they are from the following organizations: CUPE, the Canadian Power Engineers and Skilled Trades Union, IBEW, OPSEU, SEU Local 210, and the Windsor and District Labour Council. As such, we speak for several thousand health care workers and consumers in Essex county. Unfortunately, we have recently withdrawn our support of the reconfiguration project, primarily due to the current government's decision to renege on promises made to this community. Notwithstanding this, we continue to be advocates for true health care reform in this community.

It is understood that the focus of today's presentation is to be on health-related matters, and our submission will primarily deal with this. However, it cannot be overstated how other sections of this bill have a direct and negative impact on the social fabric of this community, and thus the health and welfare of all who reside here. The current cuts to social services in income, housing and child care benefits have placed an already enormous burden on those least able to survive the blow. When seniors and lower-income citizens are faced with additional spending challenges in contemplating a host of user fees for everything from garbage pickup and library cards to health care services and lifesaving medicine, it does not take a brain surgeon to imagine the devastation that may follow.

One of the most disturbing elements of the Ministry of Health Act is the deletion of section 8 with respect to the establishment of district health councils and its replacement with a section that creates the Health Services

Restructuring Commission. The specific mandate of this commission is yet to be defined by regulation, but it is clear that it will have the power to implement such government objectives as forced hospital closures, all without public consultation at the local level. While the current system of appointments to the local DHC is not without its flaws, one must certainly expect that local bodies would be more responsive to the needs of the community than such a commission will be. The lack of reference to DHCs in this bill gives rise to the real expectation that they may have reached their sunset years. Given the role that the local community members and the district health council have played in developing a restructuring plan that was, at least in its conception, to have provided a blueprint for the province, it is totally unacceptable to even contemplate removing our local district health council from the ministry's scheme.

Despite the problems that have recently arisen with the implementation of the Win/Win report, mainly by reason of the minister's refusal to ensure retention of savings for needed community supports, the labour advisory committee is still committed to the fundamental principles contained therein. The promises made to this community cannot be breached. We would not stand idly by and watch the work of several years go down the tubes under the direction of the Health Services Restructuring Commission.

The changes put forth under the Public Hospitals Act are sweeping in their scope and impact. Previously, sections 5 and 6 of the act gave the minister the power to fund public hospitals, as defined by regulation. However, Bill 26 replaces these sections with clauses that give the minister discretion over what criteria for such funding will apply. The only criterion that must be considered is that of the public interest.

Section 6 of this act will now give unilateral power to close hospitals, order amalgamations and specify services to be delivered, all under the so-called public interest. The ministry has already made it clear that it thinks inpatient services are excessive, so Bill 26 will impel hospitals to perform more treatments and procedures on an outpatient basis and to achieve smaller and smaller length-of-stay ratios, a trend we consider to have already produced unhealthy results. Under this approach, patients will continue to be pushed out of the system too quickly or denied appropriate levels of care.

When Essex county volunteered to close two acute care hospitals, it was promised that the savings would be reinvested in sorely needed community services. The ministry thus far has failed to heed warnings from physicians and providers of acute and community care services that hospitals cannot be closed and bed utilization significantly reduced without a network of community supports. In fact, far from honouring the commitment for approximately \$22 million per year, the minister has chosen to announce that 18% of the hospital budgets will be clawed back in the next few years, with no reassurances that any funding will enhance community care, which only causes us concern about the already dangerous levels of health care that are being provided and ensuring patients will not be dumped on the streets, sicker and sicker, with nowhere to go for required health care services.

Previously, the minister was precluded from making any decisions on the basis of financial reasons alone without considering the effect on patient care. What is particularly disturbing about this bill is the enshrined definition of "public interest," which now includes the availability of financial resources and, for that matter, any other matter the minister and cabinet rely on as relevant. Of course, if the minister chooses to direct less funding towards health care in an attempt to meet the promise of tax cuts for the wealthy, he will legally be protected from the consequences of the decision made.

In case that isn't enough to set our heads spinning, the minister now has expanded powers to appoint investigators and supervisors whose scope of investigation includes "any other matters relating to a hospital where the Lieutenant Governor in Council considers it in the public interest to do so." Should the hospital board resist the direction of this supervisor, they can essentially be removed. Once again, full legal protection is afforded to all.

The LAC sees the changes to the Independent Health Facilities Act as not only a foot in the door, but a wide-open door for private, for-profit American corporations to enter the health care business in this province. For Bill 26 redefines independent health care facilities to include any facility or service that the ministry defines by regulation. Furthermore, this bill eliminates all preference for non-profit or Canadian operators and allows the minister to invite proposals for new facilities from whomever he chooses. American corporations have for some time now dreamed of cracking the "unopened oyster"—that is, the Canadian health care system—and of providing care for the elderly, which has been termed "mining grey gold." Changes to this act bring their dreams and our nightmares a frightening step closer to the light of day.

These changes set the stage for expansion of independent health facilities in the system and permit them to charge fees to insured persons, ie extra billing. Furthermore, the definitions of "health care" and "health record" are repealed, and references to "insured" when referring to services deleted. This sets the stage for deinsuring services and implementing user fees contemplated in other sections of Bill 26.

Changes to this act also may result in a breach of confidentiality of patient records, for it gives the minister the power to collect and disclose patient information for the purposes of administration of this act. Once again, when the so-called public interest is at stake, the right to confidentiality of patients' private medical information is up for grabs, with no legal recourse to those affected.

Ms Valerie Walter: The changes outlined in schedule G heave the most dire consequences on the sick, the elderly and the poor, while providing immeasurable benefits to huge international drug cartels. Presumably, such companies as Star Kist and Oscar Meyer will also do well.

Under amendments to the Ontario Drug Benefit Act, seniors and social assistance recipients will be expected to absorb new user fees, regardless of their income levels and realistic ability to pay. The Tories promised that there would be no user fees and that services to seniors and the disabled would not be touched. The changes to

the act belie these promises, and once again place the greatest tax burden on these most vulnerable people.

The minister has put himself in the position of overruling physicians and pharmacists when it comes to determining what is medically best for the patient, for under this act patients will be responsible for paying the difference between the generic drug and that prescribed by their physician, even if the generic drug is unsuitable for that patient. Medical necessity or other health criteria will no longer have to be considered. Cabinet will now be able to establish their own clinical criteria in determining what will be covered. In fact, the minister may consider the total cost when designating or removing the designation of a drug product. I wonder if the cost of human suffering will be part of his deliberations.

It is clear that user fees will not reduce the need for prescription medicine. Rather, they will limit the ability of seniors and those of limited means to actually fill prescriptions for what may be lifesaving medication. The true culprits in the rising costs of the Ontario drug benefit plan—the high cost of drugs compounded by the federal government and Bill C-91, and overprescribing by physicians—will remain untouched, and once again it is the innocent victims who will be expected to pay.

1640

And speaking of the high cost of drugs, the Tories in their wisdom have seen fit to render Ontario as the only province no longer regulating the cost of drugs. The legislation removes any concept of a public process for setting the price of drugs and for determining other matters related to the Ontario drug benefit plan. To the government's contention that this deregulation will actually lower the price of drugs, we can only respond that hallucinogenics are obviously too easy to procure. With high costs of drugs under regulated prices, can we really expect the huge drug companies to suddenly get an attack of compassion and lower prices when under deregulation the sky's the limit?

Under schedules H and I, significant changes are made. Once again the minister is given tremendous powers to determine what he considers to be "medically necessary" services. Previously, the Health Insurance Act required OHIP to cover all medically necessary services provided by MDs as negotiated with the OMA and defined by regulation. However, cabinet will now be authorized to decide what services will be insured "under such conditions and limitations as may be prescribed."

Payment of fees will be decreed by cabinet, thus removing any negotiating capability of the OMA. The fees could vary for different classifications of physicians and practitioners, and fee schedules altered in almost any manner considered appropriate. Furthermore, accounts submitted to OHIP by physicians for services that were not deemed to be medically or therapeutically necessary could be denied.

The impact of these amendments on services provided in hospitals and health facilities is also worth noting. Despite the fact that the bill defines prescribed services, they too must be rendered under "such conditions and limitations as may be prescribed." Ultimately, these provisions may be used to limit access to services now covered under the Health Insurance Act, for no other

reason than that they are deemed too expensive. Criteria may also be set in determining what is considered necessary, and provisions are in place to ensure that "such services may be prescribed only if they are provided to insured persons in prescribed age groups." Let the pogroms begin.

Of course, this section of the act, as do many others, gives the minister and the general manager of OHIP the power to collect and disclose patient information for any "purpose as may be prescribed." This could lead to the ministry contracting out aspects of OHIP administration, thus providing personal medical information to private corporations. Just think of the consequences of this ability of private corporations to access medical records. Think of the insurance claims that will be denied or access to insurance that will be limited. In all this, once again, the minister and general manager are exempt from prosecution as a result of their disclosure.

The power over physicians in this act and in the new Physician Services Delivery Management Act is truly mind-boggling and an affront to democracy. Not only will fees be prescribed by government, but regulations may require physicians to make contributions to OHIP, impose retroactive fee reductions, restrict billing numbers and force the physician to practise in a particular area. While giving the government the power to completely avoid all legal obligations with the OMA, Bill 26 continues to hold the OMA to those obligations the government decrees upstanding. The effects of these and other acts will give the Minister of Health and cabinet absolute legal authority to dictate the terms under which physicians provide medical services in this province.

While the LAC is on record as stating that changes must be made that deal with overprescribing and referral patterns that may contribute to the inefficiencies and waste in the health care delivery system, this totalitarian approach is completely unacceptable. What it will only serve to do is drive experienced physicians out of the province, and in Windsor we are particularly vulnerable to the threat of our MDs packing their bags and heading south. The health system reconfiguration project was to have offered a better deal to this community: comprehensive yet streamlined services in both the hospital and community care sectors, greater satisfaction for front-line staff, and, through these, the ability to attract qualified physician specialists such as neurosurgeons and obstetricians who are sorely needed. We ask you: What physician in her right mind would even think of considering a career move to this province, given the severe limitations that are being placed on all matters affecting a physician's practice?

Unfortunately, the list of affronts perpetuated under Bill 26 just gets longer and longer, for under the Health Care Accessibility Act cabinet is given direct authority to regulate extra-billing on insured services. This could mean a host of user fees on virtually everything from breakfast to bedpans, with unlimited capabilities for recouping huge reductions in hospital funding at the expense of the patient unfortunate enough to require care.

For example, it has been suggested that hospitals may be allowed to charge a daily user fee to patients in acute care beds awaiting placement in a long-term care facility

or nursing home. Patients therefore will be made directly responsible for having been put on a waiting list for services that have been chronically underfunded as a result of government spending policies.

We are not amused.

Ms DeBellis: The decision to remove the proxy method of pay equity evaluation effective January 1, 1997, will have a profound effect on some of our members, for example, nursing home employees, who most likely will have no male-dominated job classes of employees to which they may compare. These workers are traditionally the lowest-paid in the health care field, and the decision of this Tory government to snatch away the only opportunity for fair pay that these hardworking health care providers are likely to achieve is met with contempt by members of this committee.

In the health care sector, the amendments contained in schedule Q are reflected in changes to the Hospital Labour Disputes Arbitration Act. Bill 26 sets new criteria for arbitrators to consider ability to pay and service levels when issuing their award on interest disputes.

Considering that funding in the public sector is determined by ministry policy, it would be a simple matter for the government to pre-determine pay and benefits long before the negotiating process even begins by cutting hospital budgets. Employers as well could unilaterally budget for wage freezes or concessions, as Bill 26 will virtually eliminate any incentive they may now have for entering into true collective bargaining.

As early as 1965, an arbitrator, Harry Arthurs, in an award concluded that consideration of ability to pay would make the interest arbitration process a sham. Despite this, Bill 26 now gives arbitrators the right to reduce services, lay off workers and anything else deemed necessary to meet the budgetary requirements.

Historically, public sector workers have been deemed to perform essential services and thereby denied the right to strike. Under changes to the Hospital Labour Disputes Arbitration Act, these workers will no longer be able to rely on a relatively balanced system of determining what is fair through the arbitration process. Arbitrators will be forced to become agents of the Harris government to deny collective bargaining rights to so-called essential public service workers.

Given that this current government is in the process of introducing measures that will eliminate thousands of hospital workers, it seems ludicrous to hold on to the myth that Mr Harris considers them essential by anyone's standards. It is therefore the contention of this committee that any or all legislation forcing compulsory arbitration on public service workers, including health care workers, be repealed so the parties may exercise their democratic rights to collective bargaining through the option of resorting to strike and lockout mechanisms.

Ms Walter: In conclusion, Bill 26 is nothing about fairness. It's not about controlling a wayward deficit or about health care or tax reform. What it is simply is a blatant attempt to gouge the pocketbooks of those least able to afford it: the sick, the elderly and the poor, including little children who have committed no sin other than having had the misfortune to be living in Ontario during this regime.

It is purported to be about the relinquishment of government powers and the devolution of these powers to the local level. However, while it certainly devolves responsibility for funding far from Toronto, it sets up such an amazing array of unilateral, unimpeachable powers that one must wonder if we're now living in a police state.

It is an assault against working people, who are the backbone of this province and of their communities, who have shed blood, sweat and tears in their efforts to establish the social programs that have made this country so unique.

It is the selling off of essential services to for-profit private corporations that care little about what is best for the citizens of this province but care greatly for the bottom line.

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It is about the betrayal of the people of Ontario, who were fed a string of lies during the heat of the election campaign and who were innocent enough to believe these empty promises.

It is about a government that is willing to put itself above the law and deny the citizens of this province the right to appeal and to their day in court.

People will die because of this bill. I repeat: People will die, the ultimate price to pay for this government's irresponsible policy.

Seniors faced with user fees for drugs while on a limited income will have to make the choice between lifesaving medicine and other necessities of life, and some will die.

The elderly, too sick or infirm to care for themselves at home and awaiting placement in a nursing home, may find their lifelong savings eroded by hospitals forced to offset their own budget reductions with user fees. Some patients, in desperation, will go home, despite their medical need, and some will die.

Hospitals will be forced to achieve smaller and smaller target rates for bed utilization and patients will be dumped on the streets sicker and sicker, with no community supports in place, and some will die.

Mothers suffering the effects of cuts to welfare, housing and child care benefits will face additional user fees for drug and hospital services, not to mention municipality-applied user fees for a variety of necessary services. They will be forced to choose between medical care and shelter or food for their children, and some children too will die.

It is a sham. It is a disgrace. It is a crime. In the name of decency, in the name of democracy, in the name of God, we urge you to scrap this unholy bill.

Ms DeBellis: Along with our presentation, we do have petitions. Petitions have gone out for the last week. We have over 1,000 signatures that we'd like to present to the committee today.

Ms Lankin: Thank you very much. Reading this propaganda again, it says, "Myth: Bill 26 was written without consultation or input from those affected," and it says, "Reality: Before drafting Bill 26 each minister held extensive consultations...." Would I be right in guessing that no one consulted with you?

Ms DeBellis: No.

Ms Lankin: I thought I might be right. Of course, I know why: because you're a vested interest group.

Ms Walter: Yeah.

Ms DeBellis: Right.

Ms Lankin: Let me talk about your vested interest and the folks you represent. I'm kind of tired of hearing people marginalized in their opinions, sort of denigrated because they're a vested interest, and particularly labour. This government is so anti-labour. It's so clear.

Labour has been an integral part of the restructuring in this community. Sure you had problems here and there and you fought for your points of view, but you participated and you believed in the process and you believe restructuring has to take place.

I find it amazing that with all of that participation and goodwill, they'll just turn around and sort of say, "Well, on the other hand, okay, we're going to attack you from another front that we didn't even talk to you about, like changes to the arbitration act to impose ability to pay." They obviously consulted with somebody with respect to that, hospitals and municipalities, I suspect.

And we know that over and over again, in 1985, when the Tory government introduced wage guidelines and put ability-to-pay criteria in legislation, arbitrators rejected it, because they said essentially, from their point of view, ability to pay is the willingness to pay. How can they tell whether a municipality's going to raise taxes or not or take it out of salaries?

Nursing home employees in for-profit nursing homes: The employer decides how much profit goes to the bottom line, and what's left over they go to arbitration. Who are the employees of the for-profit nursing homes, and what does this mean without pay equity protection and with this new legislation on arbitration?

Ms Walter: I guess what it means is that the people in nursing homes, who are traditionally the lowest-paid health care workers, will have, under the cuts and everything and under the backlash from the hospital restructuring, more and more heavier-care patients to care for and nothing out there to ensure that they get a fair and adequate wage for the services that they're providing.

Mr Clement: On page 4 you say, "American corporations have for some time dreamed of cracking the 'unopened oyster' that is the Canadian health care system and of providing care for the elderly, which has been termed as 'mining grey gold.'" Since this has been the third time in the labour briefs that we've heard today that we've had that terminology and probably about the 10th time the committee has heard that, I'm just curious: Which American corporations are you talking about who have said "unopened oyster"?

Interruption.

The Chair: Please, I think these ladies can answer the questions.

Mr Clement: Did you have a name of an American corporation?

Ms DeBellis: I don't have any names.

Mr Clement: So where does this paragraph come from? Where did you get this paragraph from?

Interruption.

Ms Walter: Well, this is more important. First of all, I think American Liberty has made it very clear that they

are interested in health care. There are advertisements already on Windsor television for insurance corporations to cover health care in Canada. Our brief was compiled from a number of sources, including the Ontario Health Coalition, the OHA, we've looked in the regulations, we've looked in the Sack Goldblatt—is that—

Mr Clement: And Mitchell.

Ms Walter: —assessment.

Mr Clement: A legal brief, right. Could I just turn to page 3 for a second? You talk about how we are advocating the closure of 38 Ontario hospitals that we have declared redundant. That's in the third paragraph. Sometimes, when we Tories talk, we talk about the 9,000 empty hospital beds which are the equivalent of 38 small-sized hospitals in Ontario that we're still paying the heat, the light, the administration for and how we want to restructure the hospital system so that we can deliver the health care services to where it's truly needed. Is that what the reference is?

Ms DeBellis: Once again, that was from our document and this was over and above, that there are 38 hospitals to close.

Mr Clement: Well, that's false.

Mrs Lyn McLeod (Fort William): I very much appreciate the thoroughness of your brief, and if the government is so convinced that it's advocating open and consultative processes even when it comes to new independent facilities, we might wonder why there is no request for proposals. They're not even going to invite people to make proposals so they can look for what might be the best offer.

Your brief is so thorough I'm not sure what to touch on. I think there's maybe one thing that you haven't specifically mentioned and that I think is worth mentioning, and that's that this is a bill that comes from the Minister of Finance. This is a finance bill. I'm sure you're as frustrated as we all are when you hear the government members talk about restructuring the health care system in order to be able to do important things like shortening the list for heart surgery when you know this bill is not about health care restructuring, it's not coming from the Minister of Health, and in fact it makes the Minister of Health subservient to the Minister of Finance. So this is about taking \$1.5 billion out of health care and about giving themselves the powers to make the cuts fast, and I don't believe you can make a case that you're going to have a better insurance of shorter lists for cardiac surgery when you arbitrarily force the closing of hospital beds by taking \$1.3 billion away from the hospitals.

I share the concerns you've expressed in your brief, and one of the things you've touched on that not all presentations pick up is that when it comes to closing hospitals, the Minister of Health is actually putting himself beyond the law. He's not even governed by regulation under the hospitals act.

You've mentioned the importance of the district health council and local input. I'm surprised Mr Clement didn't use his time to talk about the fact that the district health council—

Ms DeBellis: He already did.

Mrs McLeod: —hasn't been sacrificed yet. That's perhaps to come in amendments to future acts. But there's no guarantee of local input, and as you have noted, there's no guarantee of the dollars that are saved by restructuring coming back into a community. I guess I'd just like to ask you to comment a little bit more. This is a community that's gone through a lot of anguish in looking at hospital restructuring in order to save dollars and in order to make sure some of those dollars go into community care. What do you need in a community to have an incentive to bring about real savings, not arbitrarily forced savings?

Ms DeBellis: I want to say at first that this bill has nothing to do with improving our health care system.

Mrs McLeod: You're right.

Ms DeBellis: Far from it. With restructuring, labour was part of restructuring, the Win/Win book, and you bring the stakeholders, you bring all the parties together, and it's amazing what can be accomplished. We are true partners. Looking at labour as, "Oh, here they come, a vested group," we're not only—we are looking out for our members but also for the consumer. We're consumers as well; we use health care, we use a lot of the programs and services. But we need commitment from the government. If you want people to stay in hospital a lot shorter time, you've got to have the community services out there, because people are falling through the cracks; they're doing it now. We have the elderly, we have the poor. They are the first ones who are going to get hit. We need to have community services.

The Chair: Thank you very much. We appreciate your presentation.
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ST JOSEPH'S HOSPITAL

The Chair: Our last group for the day represents St Joseph's Hospital in Chatham. Welcome.

Mr Stephen Fuerth: I'm the chairperson of St Joseph's Hospital in Chatham. With me today are Richard Kuhn, chief executive officer of St Joseph's Hospital; Linda Millard, assistant executive director of patient services; and Bonnie Wooten, a member of our board of directors.

On behalf of St Joseph's Hospital in Chatham, thank you for the opportunity to address the committee with respect to Bill 26. We made the decision to seek out the opportunity to appear before the committee because of the potential impact of the bill on the delivery of health care in our community. We believe it is important that in its deliberations on this bill, the government has the benefit of a broad range of views concerning the bill from the public and from the various providers on such a fundamental issue as health care. The comments offered today by St Joseph's Hospital are intended to give the government some constructive feedback on the provisions of the bill as they affect community hospitals.

The concept of fundamental community planning and restructuring of service delivery of health care in our local community is certainly not an idea new to Kent county. Throughout the past several years, St Joseph's Hospital has been an active participant in the efforts of

our community to come to grips with declining provincial funding, downsizing, and the efforts to rebuild a system that is sustainable for the foreseeable future. These efforts began several years ago in negotiations with other Kent county community hospitals concerning the rationalization of services and has extended more recently to our participation in the study of our local health service with the district health council, the Kent county hospitals, public health, and representation from labour and from medical staff. St Joseph's Hospital has also been involved in a strategic partnership with local municipalities, school boards and sister hospitals known as KAAG, Kent area administrators group, for the express purpose of maximizing use of taxpayers' dollars.

The board of St Joseph's has demonstrated throughout these efforts its commitment to plan for change, and its appreciation of the need to find new models for the delivery of health care. There is a commitment by our board to develop new relationships with the other deliverers of health care in our community, including our sister hospitals, physicians, our hospital workforce, community agencies and the public itself. In the meantime, we have managed our resources carefully and prudently and we have opened our processes to be more open to the public and therefore more responsive and accountable to our community, while at the same time ensuring that the standard of care in our programs remains of the highest quality.

St Joseph's Hospital acknowledges the vital provincial interest in the delivery of care in our hospitals, and as we struggle with the need to maintain our present level and quality of the services we provide to the public in our area, we also understand that we have to do so with fewer financial resources from the provincial government. Indeed, all our planning efforts over the past five years have been based upon fewer real dollars coming from the province, and we fully understand that we have likely only seen the tip of the iceberg in this regard.

Our hospital has worked cooperatively with the provincial government in local restructuring studies in this time of fundamental change. Our purpose in coming today is to make constructive comments about the form chosen by the government with respect to future provincial participation in the local planning and decision-making processes.

The province of Ontario ensures the fulfilment of its health care responsibilities in large part through small community hospitals throughout Ontario. For example, St Joseph's Hospital in Chatham has continued a long history of identifying local needs, implementing new programs and services in response to these particular health care needs, and in the course of doing so, raising capital from the public to meet the fiscal requirements that the development of these new programs inevitably brings. In doing so, we have had to cope with limited resources and foster strong commitments and close working relationships with our customers, which include our patients, staff, physicians and community agencies. This is the challenge for community hospitals, but it is also one of our traditional strengths and a resource well worth preserving.

This leads us to our first recommendation for consideration by the standing committee. We believe it is inevitably

healthier for the small community, and the solutions more viable and sustaining, if the decisions about local needs and the utilization of local resources, including not only the physical and financial resources but also the human resources, are left to the community itself. While we understand that there is always a potential for honestly held beliefs of dedicated community members to develop into an impasse with respect to potential solutions for fundamental change, it is also true that decisions made in Queen's Park are not always easily accepted at the community level. As a preliminary step, therefore, the province ought to facilitate a resolution to local impasses by using its expertise and persuasiveness in uncovering compromises at the local level. If more conclusive provincial input should be necessary, either through the Health Services Restructuring Commission or otherwise, we believe that such an extraordinary provincial intervention should be accountable and subject to a fair and equitable process.

Therefore we make the following recommendation: In order to ensure accountability for decisions concerning fundamental structure and major change in service delivery, the Health Services Restructuring Commission act in an advisory capacity only to the minister, who shall ultimately be responsible and accountable for such decisions.

In the event that the government chooses the vehicle of the commission to effect provincial policy in local communities, then as an alternative we would make this recommendation: that the commission be held accountable for its decisions and conduct its deliberations in a fair and open process, including with it the obligation to give those affected reasonable notice of its intent to act and an opportunity for a full and fair hearing. In doing so, there ought not to be immunity for the commission in its decision-making processes.

The next area I want to talk about is merger, closure and amalgamation, what I call the extraordinary remedy. The proposed powers in Bill 26 with respect to closure, merger and amalgamation of hospitals by the commission, the writing of hospital bylaws and the requirement to provide certain services and level of services represent a significant and extraordinary change in the relationship between the purchaser of services, which is the province, and the local community providers. We believe the government appreciates that such extraordinary remedies have the potential of striking at the heart of the community hospital and can result in the nullification of the hospital's very mission and purpose.

The loss to the local community by the exercise of such extraordinary remedies would be great and would include the following: potentially the loss of a valuable community charitable trust with a proven record of providing health care services and raising capital for the benefit of the local community; and also a real sense of loss and a corresponding harm to the social fabric of the local community.

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In this regard we recommend to this committee that you consider the following: that the exercise of such powers as amalgamation, merger, closure of hospitals, replacement of trustees, writing of bylaws and dictating

the services to be provided take place only after a full and fair deliberation exercised with due process.

We understand that in terms of making provisions for these powers, the government is prepared to consider a sunset provision with respect to their exercise, and we wish to state our very strong support for such a termination to the existence of such powers. We also strongly recommend to the committee that the extraordinary powers given to the supervisor also be subjected to the same sunset provision. If there is no light at the end of this tunnel, we are concerned that there's going to be little incentive for local initiative, unless the government clearly enunciates closure with respect to these provisions.

There is little indication in the bill of the basis upon which the government intends the minister, the commission or the supervisor to act, other than what it considers to be in the public interest. This is indeed a very broad brush, and if the province wishes to maintain the restructuring process as a cooperative effort, it would be very useful for the government to enumerate what it means by "the public interest." We understand the government intends to exercise its discretion out of a concern for its fiscal responsibility, and in that endeavour you have the support of our hospital. We understand the need to find solutions to the problems created by past spending practices and what some might view as largess in funding hospital care, and we affirm to this committee that it is a strong Catholic principle to be prudent and careful stewards of the taxpayers' dollars while at the same time meeting community needs.

However, we also believe as a community hospital that it is also in the public interest that the quality of care not be impaired in the rush to save money. For the past several years we have had to struggle with this very issue as the level of provincial support has dropped for our hospital. The issue is how we maintain services and the quality of those services with fewer dollars. We believe that to date, community hospitals have met those challenges responsibly, and if the province wishes to engage in the fundamental restructuring this bill contemplates, we would suggest that the level of services and quality be part of the criteria. In addition, as a community hospital we are also concerned about the availability of services in our community and whether basic medical services will continue to be available locally. The trend to regionalization is one which, in our opinion, must be resisted for access to basic levels of primary care, and accessibility ought therefore to be an additional criterion.

We have not attempted to enunciate all the relevant criteria for the exercise of provincial discretion. We have simply attempted to demonstrate the need for the enumeration of principles and a subsequent public debate as to their sufficiency, but our recommendation is as follows: that Bill 26 define the criteria for the exercise of powers given to the minister, the Health Services Restructuring Commission and the supervisor, and further provide that the exercise of those powers be subject to the consideration of those criteria.

With respect to the provisions of the bill related to the increase of powers to the supervisor, we reiterate our comments with respect to the need for a sunset provision.

We also endorse the limitation on the right of the supervisor to exercise his or her powers for the reasons set out in clauses 9.1(c) and (d) only for the period of four years. In this regard, we support the position of the Ontario Hospital Association.

On behalf of St Joseph's Hospital in Chatham, I want to take this opportunity to thank the government for the time it is taking to study Bill 26. Part of the success of our health care system in Ontario has been the traditional empowerment of local communities to have input into the planning and a measure of control over the delivery of its own care.

We recognize the complexity of the task you are undertaking and your desire to have the tools necessary for your task. These factors point to the need for careful deliberation and reflection upon the implementation of these policies.

Thank you for giving me that opportunity.

Mrs Ecker: Thank you very much for taking the time today to put forward some suggestions and concerns you have about Bill 26. I think you put very well the importance of local community hospitals, the role they play in the system, and I think also you have reinforced well the role of local planning and the need for that. That is exactly why the minister did not remove district health councils from the legislation and is continuing to allow them in their capacity to advise, to recommend to the minister, to do local planning.

We have heard suggestions from many that we need to make that more explicit in reference to the hospital commission, and I think that is an excellent suggestion that the committee members here have certainly been prepared to recommend.

You talked a little bit about the investigators and that you thought the powers of the investigators should be sunsetted. Should they be sunsetted, or if there was a due process for their use in terms of situations where you would foresee they might well be used, what would you advise?

Mr Fuerth: I didn't say anything about the investigators; I talked about the supervisor. In any event, they're in the same section of schedule F, so I'll respond to the question. I abhor any process that doesn't have due process as part of it, and I have real concern about the powers I see in schedule F to the bill. Accordingly, I would suggest to you that at a very minimum, there needs to be due process as part of the consideration in the exercise of powers. You've provided in this bill extraordinary powers of investigation and management of local community hospitals. Quite frankly, it had better be an extraordinary situation before the government steps in and exercises these powers. Let's face it, the government has to be accountable for this, so there should be either a minister who's responsible to make these decisions and accountable to the public, or a fair hearing and a fair process in order that accountability be ensured. There has to be one or the other.

I could accept as a fallback position that there be a sunset clause, but we need to know that at some point these extraordinary powers are at an end. If the government is going to embark on this bill and on these provisions, we should all recognize that these are extraordinary

powers in very difficult times, that four years perhaps is an appropriate period and then we start with a clean slate again. For that very limited purpose, I endorse a sunset clause.

Mrs Ecker: You've recommended that we define the criteria for the exercise of the powers given to the minister, the commission and the supervisor. Any specific suggestions on what some of those criteria might be, from the experience you've had?

Mr Fuerth: We've outlined a couple of areas, but this is an area of provincial concern. This is your bill, your attempt to have the province intercede in the local community and make decisions and exercise management and control with respect to local providers. What I'm suggesting to you is that it's your onus, your responsibility, to set out clearly what the provincial policy is, what the criteria are that you think important in making these judgements, not what I think is important. You're the one with the power, so you tell me what you think is important in the exercise of your criteria.

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Mr Crozier: Thank you, ladies and gentlemen, for your presentation. I want to say at the outset, as I said earlier today to the presentation by the Hôtel-Dieu Grace Hospital, that I happen to believe—and I've been in the Legislature a short time—that all legislation should have a sunset clause. Every piece of legislation should be reviewed at some point to see if it's doing the job it's supposed to do.

Having said that, and noting that you have made comments about limiting the powers of the supervisor to only four years, let me put it as the Ontario Hospital Association has. And you mentioned due process, that if we had due process, you perhaps wouldn't be concerned as much that we have a sunset clause. The Ontario Hospital Association says it should be limited to March 31, 1999. "The statute will assist hospitals and the government in restructuring the hospital system, yet at the same time preserve for the future the fundamental principle of voluntary governance."

As I said, I asked this question once before today: Why, if we believe in the fundamental principle of voluntary governance, would we say, "But we'll give it up for four years"?

Mr Fuerth: The government has indicated in a clear statement what its intentions are. I think the agreement, at least in the extraordinary circumstances, to a four-year provision is intended to be a compromise: "If we have to have it, we'll accept it under these terms and we'll live with it." The only additional item we've attached to the exercise of those powers is that it be exercised only under due process. We've taken that position and we support OHA because it appears that the government is intent on having and exercising these powers, and the suggestion is that they do it within their mandate.

Mr Crozier: I'm having a hard time understanding why you would do that, because there are some things in this bill—in fact, if the bill had been passed in December the way it was originally going to be, it would have made the Legislature relatively irrelevant, and when we get to regulations, we have no idea, essentially, what the

regulations are going to be for this bill, and that may be where we have another interesting time.

But I don't think I'd want to give up, just because they have a majority, for four years. Do you see what I'm getting at? I would like you to come here and say: "Look, we don't like this. Please put a process in." That would be the kind of thing I'd like you to come to the committee with. I understand. You're saying there's a compromise, and there are various reasons you might come to that compromise.

Mr Fuerth: We have an ongoing responsibility in our community to provide health care. We recognize that we have to build partnerships and that we have to work with the government of the day and with the district health council and with community agencies and with our physicians and with our workforce and with the community we serve.

We know we're in a very significant time of change, of restructuring. We've just completed in our area the work of local restructuring. We know that the next three or four years are going to be very difficult. The only thing we've attempted to say today, in addition to the OHA, is that if you're going to exercise extraordinary provincial powers at the local community level, give us a fair hearing, give us an opportunity to make our case.

Ms Lankin: I appreciate your submission very much, and I also understand from my time working with hospitals and the hospital association the tone the association has taken and the attempt you are making to find a space for dialogue with the government, given what the government is attempting to do. I understand that completely.

I'm still having trouble understanding the government with respect to this provision, however. A couple of examples: the appointment of supervisors, the stripping of the due process of the inspector's report having to be in first and having due regard, and the greater powers the supervisor has.

If it is in a circumstance where you are implementing a restructuring report of a local community and attempting to close a hospital and you're having resistance from the board of that hospital, and then you want to put a supervisor in, that's a very specific circumstance. Why, for any other reason—concern about quality etc etc—wouldn't you follow the due process rules already set out in the old act? Why wouldn't you separate it out? If this extraordinary power that's required is about closing a hospital that you think is going to buck the system, then spell it out, if that's what it is.

I asked the minister, "How many times has the government used the supervisory powers in the existing act?" Once or twice; hardly ever. It's extraordinary. So I asked him: "Why do you need something even more extraordinary? Why is 30 days too long in terms of due process?" I don't understand what is actually being requested and what is really required here, and this is very genuine.

The other thing—I guess it's a little rhetorical and I'll apologize for that—is that every hospital that's come forward has said it's absolutely committed to restructuring and downsizing, that they know the writing's been on the wall and they've been participating and they're prepared to proceed. With a little bit of grief from the

minister in terms of persuasion and working through with communities, you don't have to impose solutions. We've been finding most communities coming to their own consensus.

I am not supportive of the extraordinary powers as they are set out. I agree with you that if worse comes to worse you get them sunsetted, but I'd like to see them done away with. Failing that, I'd like to see set out why and when the extraordinary powers are going to be used, and only in the circumstance of forced closure of a hospital. Everything else should revert to due process.

Mr Fuerth: One of the curious things when I read schedule F was, why is the provision of supervisory powers here at all? If the purpose of the bill is to assist in the fiscal responsibility of the government of the day and to assist the implementation of local restructuring for the purpose of achieving fiscal responsibility, why isn't the Health Services Restructuring Commission sufficient? Why do we need this additional heavy-handed, unilateral person or office to carry out the process? But assuming that the government needs it—and it was part of our

submission—then clearly set out the criteria when it needs that power to act.

Quite frankly, as I struggled with the criteria set out in the section dealing with the supervisor and tried to relate it to hospital restructuring, I couldn't come up with a connection. I had difficulty. I understand "the public interest," and my imagination can run wild about what that might mean and that the government of the day can use it in that way too. But it seems to me that we would be better served, in understanding the rationale of the government in asking for these kinds of powers, if it would set out the criteria clearly enunciated. And as I said earlier, it's not my job to set out the criteria; it's the government's job to do that.

The Chair: Thank you very much, folks, for your presentation this afternoon. We appreciate your interest in our process. Have a good day. And thank you very much to the people of Windsor; we appreciate it.

The committee is adjourned until 9 o'clock tomorrow morning in the fine city of London.

The committee adjourned at 1739.

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

*Marchese, Rosario (Fort York ND)

Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Caplan, Elinor (Oriole L) for Mr Sergio

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Johns, Helen (Huron PC) for Mr Danford

Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

Crozier, Bruce (Essex South / -Sud L)

Duncan, Dwight (Windsor-Walkerville L)

McLeod, Lyn (Fort William L)

Pupatello, Sandra (Windsor-Sandwich L)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Fenson, Avrum, research officer, Legislative Research Service

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Première session, 36^e législature

Official Report of Debates (Hansard)

Tuesday 16 January 1996



Journal des débats (Hansard)

Mardi 16 janvier 1996

**Standing committee on
general government**

Savings and Restructuring Act, 1995

Health issues

**Comité permanent des
affaires gouvernementales**

Loi de 1995 sur les économies
et la restructuration

Questions concernant la santé

Chair: Jack Carroll
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Tuesday 16 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Mardi 16 janvier 1996

The committee met at 0900 in the Radisson Hotel, London.

SAVINGS AND RESTRUCTURING ACT, 1995
LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Good morning, everyone.

Mr Mario Sergio (Yorkview): Good morning, sir. How are you doing?

The Chair: Fine. Thank you, Mr Sergio.

Mr Sergio: It was nice of you to provide candies this morning.

The Chair: London does things in a special way. That's why we have candies in London. Welcome to everyone this morning. We are delighted to be in London as another stop on our tour through the province. We welcome everybody who is here this morning to listen to the presentations on Bill 26. Before we get on to our first group this morning, we have a couple of motions that we want to have introduced by Ms Lankin and debated very quickly. So, Ms Lankin, I will give you the floor.

Ms Frances Lankin (Beaches-Woodbine): My first motion:

Whereas there has been overwhelming public interest in Bill 26 and that 46 groups and individuals have requested to appear before the standing committee on general government in London, which far exceeds the 15 spaces available today for hearings;

I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged for the community of London;

Further, that this committee recommends that the three House leaders meet as soon as possible to discuss this issue.

The Chair: Can I have all-party approval to limit the debate to one speaker for one minute. Agreed.

Okay. Ms Lankin, the floor is yours.

Ms Lankin: I'll reserve a couple of seconds just at the end in case there's anything that Mr Clement says to provoke me that I need to respond to.

Mr Tony Clement (Brampton South): Who me?

Ms Lankin: The bottom line here is that while there was an agreement for the schedule of hearings, we all know the overwhelming public response that we have seen. We know that there are over 1,000 groups and individuals who have applied to come before the two subcommittees in the two weeks that we're travelling and there are less than 300 spaces available.

I hold firmly the belief that this bill is too large and too complex and needs to be divided up, and I commit to our party's agreement to pass necessary parts of the bill on the 29th, but pieces that could take a longer look and need a longer look, to have that done. But the bottom line I think is that in a participatory democracy, when this many people want to be heard, I think the opportunity should be created, and that's why I ask the government members to join me in this recommendation.

Mr Clement: I sympathize with the intent of the motion but I don't agree with its premise. I think that certainly by the end of this week we'll have had 750 presenters at both sides of the committee who have been able to present to this committee on this very important bill; very different approaches by some of the presenters that we've had so far, some highly critical of the government, some positive on some aspects of the legislation and some like the entirety of the legislation. So we've seen the variety of views, and I think in that sense the process is working.

But at the end of the day, we as legislators have to get on with the job to restructure the health care system to ensure that we have a health care system that is viable, and that means that we have to stick to the agreement that has been outlined by the House leaders and get this bill through by January 29. So I'm comfortable that we're on track.

Mrs Sandra Pupatello (Windsor-Sandwich): The comments made by Mr Clement certainly support the motion and I hope he'll vote as such. I must say that especially in the area of health, where every day, as Mr Clement mentioned, we are finding all of these new nuances in terms of how the bill affects us, it's in our best interests, it's in the health of Ontario's best interests that we continue the hearings. In particular, in light of the number of people who do not get the opportunity to speak, any kind of extension is going to be welcomed by the Liberal Party.

Ms Lankin: Mr Clement, I just want to come back to one point that you raised, which is that you think health care restructuring needs to happen and we need to get on

with it, and on that point I agree. I believe, however, those processes are under way and are continuing in communities. The problem I have with the nature of the bill is the wide-sweeping powers taken on to the government, without definition, without parameters, without an agreement of where your framework for health care restructuring and reform is.

With all of the powers that can lead us to, whether or not that's your intent, a two-tiered health care system, a violation of the Canada Health Act, I want public debate before we undermine medicare and in this province and in this country. I believe this bill can lead to that and that the protections need to be put in the bill, not in the good hands of the minister and a couple of cabinet ministers around the table.

The Chair: We'll vote on the motion now.

Ms Lankin: Recorded vote, please.

The Chair: Ms Lankin has requested a recorded vote. I'll just explain to the audience, by the way, only two people on this side have the option of voting, and three on the government side.

Actually, Ms Papatello doesn't. She's not subbed in officially?

Clerk of the Committee (Ms Tonia Grannum): No.

Mr Bruce Crozier (Essex South): She's a regular member of the committee, is she not? Mr Chair, it's my understanding that a regular member of the committee—

The Chair: Unless they were subbed for.

Mr Crozier: The clerk can clarify it. Perhaps it's Mr Sergio who can vote.

Clerk of the Committee: Mr Sergio can vote. When Elinor comes back, she can't vote—

Mr Crozier: The rest of the day.

Clerk of the Committee: Yes.

Mr Crozier: No problem; tomorrow.

Ayes

Lankin, Sergio.

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated—narrowly.

Ms Lankin: I'm very glad that we got sorted out who could vote on this side. It had such a big impact on the outcome.

Interjection: As usual.

Ms Lankin: As usual, that's right. People in the audience might know from my tone that I expected in fact to lose that motion. This is not a surprise. This is a position that I have been putting forward in hearings every day, calling on the government to understand the overwhelming response that there's been. It was clear to me that the government in fact will not entertain even a recommendation to the government House leader to consider more time on certain aspects of the bill.

That being the case, my second motion reads as follows:

"Whereas there are only four days remaining for public scrutiny on Bill 26; and

"Whereas public interest in this bill has been overwhelming; and

"Whereas the vast majority of presenters to the standing committee on general government have recommended major changes be made to the bill,

"I move that this committee recommend to the government House leader that the 106 individuals and groups that requested to appear before the standing committee on general government in London be given the opportunity today to see the government's amendments to Bill 26."

Very quickly on this, we have only four days left in both committees to receive public deputations to this committee. Beginning next Monday, the two subcommittees will be rejoined in Toronto in a hearing room to go over the bill clause-by-clause and to debate amendments. Amendments, under the rules, must be tabled by that first Monday morning.

It is both customary and appropriate that the government table its amendments in a timely fashion so that members of the public would have an opportunity to comment on those amendments as to whether or not they are in fact addressing the key concerns that have been raised and so that the opposition has an opportunity to prepare its amendments in light of the known intentions of the government. That's the way it always works.

On the first day of public hearings in Toronto, I put the question to the Minister of Health. He assured me that he would file the amendments in a very timely fashion. I'm asking him to live up to that. I'd expected them before we started travel. Here we are four days away and we still don't have them. I hope the government members will support me on this motion.

Mr Clement: Again, as I was yesterday, I'm quite sympathetic to the intent of Ms Lankin's motion, and as she knows, so is the Minister of Health. He has stated that publicly. The government has no amendments to present to the committee today, but you can rest assured that the government is working on it. We want to make sure that the amendments reflect properly the deputations and the excellent input we have had to date. We also do not want to make mistakes on it, which means that we have to do it in a considered fashion and not in a hurried fashion, as Ms Lankin is suggesting.

She says that it's customary to present as soon as possible. I understand the custom to be divided on that one. But I think it's certainly appropriate that we table them as soon as possible. You certainly have the government's undertaking to do so, but we cannot do it today.

0910

Mr Sergio: I think there's more than one reason why the motion deserves support. We have seen that the bill, when it was presented, was not understood even by the members of the government. Now we will be dealing with a bunch of amendments, not only from the government side but also from our side as well, and I think at the end no one will understand, again, an amended bill with various amendments. So I think it makes eminent sense that more time is given to hear the people who haven't been heard who want to be heard and to really delve into the matter as it stands now, as the bill plus the amendments. So I would hope that the government side will find some common sense and support and give us the time needed.

Ms Lankin: Mr Clement's sympathy is nice but it doesn't get me anywhere. It doesn't get me the amendments, it doesn't make me a more informed member in trying to deal with this legislation on behalf of the public concerns I've heard for eight days during the hearings.

I have to say that I expect there will be a vast number of amendments, given how quickly the bill was put together. I guess I'm sympathetic with Mr Clement in terms of the fact they don't want to make mistakes in the amendments the way they did in the bill. But if you drop a whole raft of amendments on us at the last minute, you will be perpetuating the way in which you've managed this bill, which is to ram it through without full knowledge, without full understanding and without full debate.

I'm aware that P and P, the policy and priorities board of cabinet, passed a package of amendments a week ago. That should be shared with us even in a draft form. I really believe that the way in which you're continuing to approach the management of this bill is inappropriate and fundamentally anti-democratic.

The Chair: We'll vote on the motion now.

Ayes

Lankin, Sergio.

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated.

Thank you very much. I appreciate your patience in allowing us to go through that process. I do have to comment on Ms Lankin's and Mr Clement's mutual sympathy for one another. It's nice to see.

VICTORIA/UNIVERSITY HOSPITAL

The Chair: Our first presenters this morning are the Victoria/University Hospital; from the board of directors, Ross Batson, the chair, Kelly Butt, the vice-chair, and Tony Dagnone, the president. Welcome to our committee. You have a half-hour of our time to use as you see fit. Questions, should you allow the opportunity for them, would begin with the Liberals.

Mr Ross Batson: Good morning. My name is Ross Batson and I am the chair of the board of directors of Victoria/University Hospital. With me is Kelly Butt, who is the vice-chair of our board, and Tony Dagnone, the president and CEO of the hospital.

We appreciate the opportunity to participate in the public hearing process concerning Bill 26, the Savings and Restructuring Act. As board members of the second-largest teaching hospital in Canada, we believe these hearings are an important first step towards ensuring quality health care for the citizens of London through dialogue with the key stakeholders.

We wish to begin our presentation by acknowledging our commitment to the delivery of quality, cost-effective health care which will meet the needs of our community and our region. Our board also recognized the difficult task the government faces in trying to preserve quality health care while responding to fiscal pressures. As members of the community and taxpayers, we recognize

that all Ontario citizens, including those involved in the health care sector, must face tough fiscal decisions if we are to ensure the long-term economic prosperity of the province.

As a teaching hospital, we believe that education and research activities in academic hospital and medical centres such as ours are at the heart of our ability to meet the future health care needs of Ontario. Our hospital has a multidimensional mission: quality health care, education and research. The combination of quality patient care, education and research will help ensure the best available health care now and in the future for the people of Ontario.

We welcome the opportunity for frank discussion and dialogue. The focus of our presentation will be to document our thoughts concerning hospital restructuring, drawing upon our own experience with a major hospital restructuring in our community, and to share with you our views on the legislation as it impacts the restructuring of hospitals; to discuss the changes to subsection 9(1) of the Public Hospitals Act; then Kelly will provide comments on the impact of the proposed legislation on our academic physicians; and we will discuss changes in the interest arbitration process.

We sincerely wish to offer our constructive suggestions for amendments to Bill 26. Our board is fully committed to working with the health care system and with our district health council to provide quality, patient-centred care for our community and the whole of southwestern Ontario. We recognize that all hospital boards must be ready to adapt to change and take decisive action with respect to hospital restructuring.

We support the government's initiative in proposing the creation of the Health Services Restructuring Commission suggested in schedule F of the Savings and Restructuring Act. We do believe, however, that voluntary governance through local hospital boards and district health councils remains the most effective way of achieving local hospital restructuring in our communities. We recommend that it would be best if the commission were to act as a body to review disputes that may arise with respect to suggested options for hospital restructuring in local communities.

We believe our own hospital is proof that voluntary restructuring, led by committed local boards, works. Victoria/University Hospital, in the space of six weeks in June and July of last year, was able to successfully complete the significant portion of a merger process involving two large and complex teaching hospitals while continuing to ensure the involvement of key stakeholders, including the University of Western Ontario and the Thames Valley District Health Council. Our only goal was to be able to better serve the citizens of London. Our board championed this cause because we saw the need for bold change by hospitals and were committed to preserving quality, effective health care.

Our experience has been that quick action and a commitment to the whole health care system are vital. Since member approval of the merger, we have been able to complete the following:

We have implemented a new hospital board structure that has brought together two previously separate hospital

boards. We now have single ownership and management under the authority of a single board of trustees.

We have significantly restructured and streamlined senior management. As little as three years ago, we had 22 vice-presidents between Victoria and University hospitals. Today we have eight.

We have redesigned our hospital's organizational structure from a department-based model to a patient-centred, interdisciplinary, team-based approach to health care delivery.

We have redefined and streamlined the middle management structure of the organization.

We are currently actively working for the integration of our medical-dental staff to make it more responsive to community and education and research needs, with a target date of June 1996.

Within the next 45 days, we will have developed a methodology to redesign our patient care programs and budgetary process which will link budget development more closely to the volume of health care delivered.

Our goal, even in light of the announced reductions in base funding, is to maintain the volume and quality of patient care in the new economic environment. This is a huge challenge. Our experience tells us that voluntary restructuring, championed by members of the local community, is the best way to address the need to maintain quality health care and reduce costs. Yes, there are some difficult decisions that need to be made in bringing together the structures and practices of two large successful organizations. However, Victoria/University Hospital is a fine example that it can be done if the resolve and commitment exist among community leaders.

We strongly recommend to the minister that he encourage all hospital boards in a community to come together and work for the benefit of the community as a whole. The forum for such a process may need to be determined by local situations in collaboration with district health councils. However, mandating annual conjoint meetings of regional-local hospital boards with an agenda to examine potential strategies for collaboration and cost savings may be an important first step. We would welcome the opportunity to develop a framework for such a collaborative process in any way we could. With the minister's support, we believe our experience can be a catalyst for significant further change within the hospital sector.

Again, to make our position perfectly clear, we strongly support the government's proposal to create a Health Services Restructuring Commission suggested in schedule F of the Savings and Restructuring Act. We agree, as a board, that government needs effective mechanisms to ensure that hospital restructuring occurs in order to preserve quality health care and facilitate deficit reduction. However, it is also our belief that the powers attributed to the Minister of Health in the proposed amendments should be used only when disputes arise or when voluntary governance models with the involvement of the local district health councils have failed in their attempts to achieve the necessary restructuring.

0920

We also strongly support the minister's recent announcement in the Legislature suggesting that the restructuring commission exist only for a three- to four-

year time frame. This announcement helps to clarify the time frame for hospitals within which this government expects significant restructuring and affirms the long-term role of voluntary governance in hospital administration.

Moving to subsection 9(1) of the Public Hospitals Act, under that subsection the Lieutenant Governor in Council has the ability to appoint a supervisor to conduct a hospital investigation if the quality of management or administration of the hospital or the care and treatment of patients in the hospital have been questioned, subject to a 30-day period under which the hospital may respond to the question.

Under the revised subsection 9(1) as amended by Bill 26, the response period has effectively been eliminated, which severely impacts any hospital's ability to be accountable for its actions. We believe the hospital should be entitled to account for its actions within a reasonable time frame before the appointment of the hospital supervisor and that the hospital be given a reasonable amount of time to correct any concerns before the minister exercises that authority.

It appears as well under clauses (c) and (d) of proposed subsection 9(1) of the Public Hospitals Act that the Lieutenant Governor in Council may appoint a supervisor for a hospital if he or she considers it in the public interest to do so. In determining what is in the public interest, the Lieutenant Governor in Council may consider the proper management of the health care system and the availability of financial resources for the management of the health care system and for the delivery of health care services.

We believe it would be reasonable in the circumstances for the powers vested in the Lieutenant Governor in Council under the provisions of 9(1), as amended, to have a termination clause of three or four years so that the extraordinary powers which may be needed to effect health care restructuring are available but do not become a tool to micromanage the system in perpetuity.

Mrs Kelly Butt: Victoria/University Hospital, as Ross said, is London's largest acute care teaching hospital, and it is Canada's second-largest university teaching hospital complex. Our hospital plays a vital role in southwestern Ontario and in the provincial health care system as a provider of specialized health for children and adults. Included in our many health care programs are cardiac care, transplantation, critical care transport, dialysis, and cancer care.

Not only do we provide high-quality health care, we are a teaching hospital. We play a vital role in the education of health care professionals, including physicians, nurses and other caregivers. We are also a site for leading edge health care research. Much of this research is done by physicians associated with the University of Western Ontario. They treat patients, they teach and they seek new knowledge. The provision of the best medical treatment and care to Ontario people is highly dependent on acute care teaching hospitals. We find the new treatments, we teach others how to deliver these treatments and we care for the patients who have special needs in southwestern Ontario.

We must be able to recruit and retain the most highly qualified physicians available, not only from Ontario but

in competition with other academic centres in Canada, the United States and the rest of the world. The effects of the proposed legislation, in particular schedules H and I, on our physicians and on the environment in which they work are of grave concern to us.

We understand that the revisions to the Health Insurance Act and Health Care Accessibility Act, schedules H and I, together with the proposed Physician Services Delivery Management Act, will give the government the unilateral power to decide which medical services will be insured and the total amount payable to the physicians providing these services.

Together, these changes also permit government to vary the basic fee for insured services for different classes of physicians and practitioners and increase or decrease this fee on certain factors set out in the regulations, including the specialization of the physician or practitioner, the relevant professional experience, the frequency with which the service is provided, the geographic area in which the service is provided, and finally, the setting in which the service is provided.

Our board has no particular position with respect to the best way of compensating physicians for their services, but we do need a system which enables us to recruit the most highly qualified physicians for service, education and research. We are concerned that the proposed legislation will drive the best physicians out of Ontario.

In a recent report by the faculty of medicine at the University of Western Ontario, it is estimated that the direct economic benefit to the London community from education and research is over \$100 million. We cannot lose that.

We strongly encourage the minister to reconsider the position with respect to these schedules. We agree that physicians must do their fair share to work within the financial constraints of the province, but we need legislation which creates an environment which encourages the behaviour we want rather than a punitive one. Should this legislation be passed, we strongly encourage the minister to put in place an alternative compensation system for academic physicians which acknowledges the unique role they play in finding new treatments and teaching the next generation of health care providers. We strongly encourage the government to work with these providers of health care to find a solution that works for all. Again, we offer the help of our organization in bringing together a solution for the government.

Let me turn now to interest arbitration. Within schedule Q of the proposed Savings and Restructuring Act, the government has made significant strides to amend the Hospital Labour Disputes Arbitration Act. We applaud and support these changes but we do not believe they are strong enough to bring about the desired results.

Victoria/University Hospital is in the midst of a merger which will have a significant impact on labour relations. In light of our own restructuring, and undoubtedly the reorganization of dozens of hospitals over the next few years, the amendments to the Hospital Labour Disputes Arbitration Act must be more clearly defined and delineated. For our new hospital, every single percentage point increase in wages awarded by interest arbitrators means \$3.5 million more in salary costs. This translates to \$3.5

million less for patient care. In the past, interest arbitrators simply did not care; ability to pay has not been an issue of concern for this group.

We then urge the government to consider the following:

First is the creation of a fixed panel of informed and knowledgeable individuals to arbitrate these disputes in a truly disinterested manner rather than the current process of union-employer selection.

There must be a clear understanding as to the type of evidence a board of arbitration is to consider when addressing the ability to pay. Our recommendation is that a board of arbitration must accept as its final evidence the organization's financial record as verified by the organization's auditor or senior financial official.

Paragraph 9(1.1)2 can be interpreted as giving arbitrators the right to impose reductions in service levels if funding levels are not increased. We believe this goes beyond the authority arbitrators should have, and as a result recommend that hospitals must continue to have the authority to determine where and how service cuts are to be made.

Paragraph 9(1.1)4 states that comparisons will be made between "comparable employees in the broader public sector." Our belief is that "comparable" is not a specific enough term and can be open to interpretation. We recommend that "employees performing similar jobs including in the broader public sector and/or the private sector" be substituted for the term "comparable."

We also believe that a board of arbitration must not require parties to include a clause in any agreement that would limit the employer's ability to contract out or to determine who shall do the work.

We strongly believe that amendments to the act should apply to any and all disputes which have not been decided at the time Bill 26 receives royal assent. If disputes already at hearing were to be exempt, one could be sure that awards would most certainly exceed the employer's ability to pay.

Finally, we support the OHA's recommendation that a decision or award be reviewed by a commissioner to ensure that the decision or award conforms to the criteria under subsection 9(1.1), and that the commissioner has the ability and the right to amend the award to ensure that the criteria have been met. We also believe the commissioner's decision should be final.

It is our belief that these proposed amendments will ensure that arbitration awards are more reflective of the fiscal realities faced by our hospitals and others in the province.

In conclusion, we appreciate the opportunity to make this presentation to you today. We have a lot of experience with hospital restructuring. We're here to help. We thank you for hearing us out.

The Chair: Thank you for your presentation. We've got about three minutes per party left for questions, beginning with the Liberals.

0930

Mrs Elinor Caplan (Oriole): Thank you for a very excellent and thoughtful presentation. I want to point out that I think the advice you've given to the government is the sort of advice that it should be hearing. If they had

passed this bill before Christmas, as they had planned, we would not be here in London today or at any time to give you this opportunity. I'm sorry there are so many people who want to come before the committee who will not be given that same chance.

You refer to the minister—and I'm going to use your terminology. I don't want to use the word "imposing" when you talk about alternative: "Should this legislation be passed, we strongly encourage the minister to put in place an alternative compensation system for academic physicians...." Are you supportive of the Queen's model and do you think that should be imposed, or should the academic health science centre be able to modify it so that it perhaps reflects the individual needs?

Mr Tony Dagnone: I believe the Queen's model is something that is one option only. I believe that through further discussions and trying to reflect on current circumstances within UWO, there is still room to improve. But those improvements will only come through a lot of dialogue between the university officials and the physicians involved in the system.

There is genuine goodwill out there on the part of the physicians to really look at a better way to compensate and to recognize those services. I believe that the Ministry of Health is also there willing to listen to looking at developing a model. Obviously we're very, very interested in doing that because the past will not carry us through in terms of the future.

Mrs Caplan: One of the concerns I have is that when you say, "The minister should put in place," that would imply fewer negotiations than you've answered in your question. I think it is important that it be done through consultation or that the academic health science centre be able to put forward proposals that can then be discussed. I would not want the minister imposing, and I'm glad that you clarified that point. I agree there is a tremendous amount of goodwill and there are multiple models that would be appropriate and perhaps different for the different centres.

Ms Lankin: I appreciate your presentation. I know a bit about the history of the restructuring you've gone through in the merger of the two hospitals and I know at times in the community in the beginning it wasn't easy. I applaud the outcome and the commitment to providing improved quality of health care in the London-Middlesex area.

I reflect on that because I have heard many times from members of the government side that all these studies were happening and nothing is being done. "That's why we need these extraordinary powers." I have to say it provokes me whenever I hear that, perhaps because I've got a little bit of vested interest in this in terms of my past. I see so much being done so well on a voluntary basis with assistance and facilitation from the ministry.

Some of the suggestions you've made with respect to powers being sunsetted, with respect to I believe some controls on when a supervisor is actually used in this extraordinary manner, all those things we agree with and we've been urging the government to make amendments along that line. We would be supportive of those kinds of amendments.

I want to make a quick comment on your position on interest arbitration, and it's to say that I understand the difficult position, as a hospital, you're in when under this new legislation you're going to be directed even more as to what services you have to provide and your funding level is being determined, yet you have no control on the other end. You're squeezed and the government is essentially a ghost at the bargaining table.

I urge you to take some caution in thinking it through, though, and I want to give you an example. A for-profit nursing home, which comes under the same labour legislation that hospitals bargain under—the Hospital Labour Disputes Arbitration Act—gets to decide what their profit margin is, determine what they have available left in terms of resources for expenditures, including salaries and benefits, then goes to an arbitration panel and sets that forward as the ability to pay. To me, there's a real problem with how this is constructed in terms of its impact, particularly on that sector of very low-paid workers. I ask you to think it through. It may not be the panacea and it could create significant problems for workers.

I'd like to ask you to make a quick comment on an issue unrelated to this bill but related to health care restructuring. The government has cancelled a program called ONIP. Your hospital has been in the lead of bringing together an amazing project called LARG*net, which has leveraged all sorts of investment. Could you just give us an update on it and let the government know the importance of that to the future of health care reorganization?

Mr Dagnone: In answer to that, yes, London is making very good progress with the help of the government grant that was provided to us. Although the program was cancelled, we are making renewed representation to government because I believe they are interested in capturing the kind of technology that we must have in the health care system so we can really do the kinds of things we're here to do in terms of improving the system.

I am optimistic that we can regroup and go forward with a request in making sure that we don't lose sight of the leadership role that London has here in the area of technology. I say that in all sincerity in the sense that it is London, the university and many other agencies, that has come together and really, in my opinion, is a demonstration site for others across Canada. We are making good use of those dollars we received in the past, and it our hope and desire that the minister will see fit for us to continue with that good work. Otherwise it's going to be waste.

Hon Dianne Cunningham (Minister of Intergovernmental Affairs, minister responsible for women's issues): Welcome to the committee, to London and to my colleagues from other places. It's a great city to live in, and I'd also like to say to the representatives of the VUH how proud we are of the leadership you've shown in the province with regard to restructuring. I know my colleagues here are very proud to be able to say thank you in the company of our members from other parts of the province.

I have three questions, probably four, so I'll go fast. Page 7, with regard to the response period, where you're

talking about the supervisors: Could you talk a little bit more about the problems you've got in this area with regard to the response time?

Mr Batson: As I understand it at this stage, the way the legislation reads is that the supervisor essentially could move in with no opportunity for the hospital to even determine if the complaint or the request that was made was a valid one. It appears there's no time for the hospital to make any kind of response or comeback.

Hon Mrs Cunningham: Are you recommending that it be 30 days, or is there another time period? What are you looking for?

Mr Batson: It's 30 days now, and I don't think we have a problem with the existing time.

Hon Mrs Cunningham: Is your recommendation then that it's working now and it should remain at 30 days as a reasonable time?

Mr Batson: Yes.

Hon Mrs Cunningham: On pages 11 and 12, with regard to the interest arbitration, the ability to pay—I have to be honest. Sitting on a school board here for many years and looking at the kinds of arbitration awards that drove the costs up in so many instances where we didn't have the ability to pay, I'd be interested in your specific recommendation with regard to this fixed panel of informed and knowledgeable individuals. Have you had experience with this in other provinces or somewhere else in Canada? I know Mr Dagnone has been involved many times. Why are you recommending this specific approach?

Mr Dagnone: We need a renewed partnership between labour and management, and arbitration is a very, very important part of the process as we try to settle disputes. It is our view that there is a lot to be gained by getting a fixed panel there so that they can develop the necessary skills and knowledge. They've got a better read of the situation as opposed to putting new people at the table every time there's a particular item to be dealt with.

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I really think we need people with the breadth of experience, people who are very, very knowledgeable in terms of new trends of labour management and have an appreciation of the kind of affordability crisis that we're in in terms of health care. Certainly I'd like to believe that Ontario could show the way and at least try it. Let's try it out a couple times and see if in fact it brings even better results for both labour and management. This is not something put forward here in support of management's position as opposed to what is really, really best for the shareholders, and the shareholders, in my mind, are the members of the public who end up picking up the tab.

The Chair: Thank you, folks. We appreciate your presentation and your interest in our process.

Mr Dagnone: Mr Chairman, may I make just one remaining statement? I really call upon, I put a plea out for all political parties to really come together, because if we're going to meet the obligation to the Ontario citizens to bring them quality health care, we need to work together. We need the minister to show leadership. We need the boards of directors to show leadership. I'd like to think that if anybody can get through this affordability

crisis, any province across Canada, it's going to be Ontario.

We do have the goodwill there by the health care providers, and I think we're talking about strong leadership here through the minister. We need his energy to create a vision. We need that vision to be articulated very, very strongly. We need all of the stakeholders behind it. Unless we do that, we're going to lose this precious commodity that we call health care. Ontario has been seen as a leader. We can't let that escape. I guess that's why I'm calling on all parties to please come together so we can get the job done. We owe it to the people of this province.

CANADIAN MENTAL HEALTH ASSOCIATION, ELGIN BRANCH

The Chair: Our next presentation is by the Canadian Mental Health Association, the Elgin branch, represented by Martha Connoy, the program coordinator. Good morning and welcome to our committee.

Ms Martha Connoy: Mr Chair and members of the committee, as the representative of the Canadian Mental Health Association, Elgin branch, I thank you in advance for this opportunity to make a presentation to you concerning Bill 26.

The Canadian Mental Health Association, Elgin branch, is a member of a national, incorporated, registered, non-profit, charitable organization. Our branch received its charter in 1961. We are one of the 36 branches in the province of Ontario. Currently we provide support services to those adults in our county who experience a serious and chronic mental illness.

These services are a range of supported residential programs: a cooperative group home, rent-geared-to-income apartments and 24-hour case management support for those living in market accommodations. Other support programs include a psychosocial clubhouse model activity centre which provides life skills for those who are living in our community.

We also offer a quality-of-life recreational program for our psychogeriatric population, along with self-help and peer support programs. Our particular branch channels our resources to developing and implementing direct service programs such as the aforementioned as well as providing community education and awareness regarding mental illness and mental health issues. It is our role and function as advocate which brings me here today.

Since our founding, CMHA has made significant contributions to the development of mental health policy. I understand this committee has heard a presentation from our provincial president, Mr John Kelly. In keeping with our provincial organization, this branch also supports the government's view of fiscal responsibility. It is agreed that this is an opportunity for transformational changes in the health care system and in particular the mental health care sector. We agree that Bill 26 will impact significantly on the delivery of mental health care services.

As a direct service representative, I encourage the committee members to review the New Framework for Support that was offered to you by John Kelly. This document, we believe, provides a framework which

examines the impact the economic statement and Bill 26 will have on our sector. This document presents a model which illustrates the integration and coordination of an improved mental health care system.

A New Framework for Support notes that persons with a psychiatric disability need more than the formal mental health services provided by hospitals, community agencies and private practice. As other citizens of Canada they need to have at least the same opportunities to basic socioeconomic support, namely, jobs or other productive activities, good housing, appropriate education and adequate income.

Individuals with a serious mental illness find they are unable to or have great difficulty in attaining employment and maintaining a home. The lack of these necessities often has a direct and damaging impact on their mental health and thus their prospects for recovery.

A New Framework for Support illustrates the ideal range of community-based resources that should be available to persons with a serious psychiatric disability, particularly if they are to live fulfilling lives within our communities. The basic socioeconomic conditions of adequate income, housing, work and education make up the foundation of this model. It has been documented that if people with a serious mental illness do not have access to these fundamental supports, they will benefit very little from other services provided to them. A comprehensive delivery system is essential.

Bill 26 sets forth mechanisms not only to achieve fiscal savings but to restructure, streamline and make services efficient. There are, however, some aspects of the government's economic agenda and proposed implementation strategies that have caused our consumers and our association concern.

As you are no doubt aware, the St Thomas Psychiatric Hospital has been identified as a facility where resources can be amalgamated with London Psychiatric Hospital, thereby achieving fiscal saving congruent with government policy. We would encourage you as legislators to ensure that Bill 26 is designed to reconcile government policy with improved services. Should our psychiatric hospital services become regionalized, provision for support services in keeping with mental health reform need to be available in smaller communities, as discussed in Putting People First. This was the strategic plan for change in the mental health care sector, and this document prioritizes services upon which mental health reform was based.

It would be anticipated that should an amalgamation be realized, there would need to be a transfer of resources to community mental health programs. This has been done in other jurisdictions. It's been done in New Brunswick, Vermont and Massachusetts without comprising care. There is evidence that clinical outcomes and quality of life for consumers have improved. Availability of and close proximity to crisis short-term hospitalization, outpatient and community support services are paramount.

A reality of our client or consumer group is that they endure a frugal living situation. The majority of our clients live on a disability pension or are Canada pension plan recipients. Transportation is often a barrier to

accessing services for our citizens as they rely on public transit or require resources to be within walking distance. For those living in outlying areas, our clients depend on the generosity of family, friends and neighbours, as rural public transit is non-existent. Few seriously mentally ill consumers for whom our association provides services enjoy an employment status where they can afford a vehicle.

As previously mentioned, our organization believes that access to educational, vocational and social opportunities should be ensured. Presently, initiatives promoting psychiatric consumer involvement have been limited. Our local PPH has developed a community-supported employment program; however, that's been limited to a few individuals. In general, educational opportunities remain open to all members of our community, the well and disabled alike. Regrettably, there is little support or understanding available for those who suffer cognitive, social and physical impairments as a result of their psychiatric symptomology. Society often displays intolerance of those with a serious mental illness. This is not stated to imply that programs should be established to meet the needs of this disenfranchised group but to suggest that resources be made available to ensure access, education and awareness opportunity to alleviate intolerance and reduce stigma.

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We realize that decent, affordable housing is not the Ministry of Health's responsibility. However, we would be remiss not to acknowledge that one's living environment has a significant impact on one's sense of well-being. It has been determined by a working committee of the mental health working group of our local district health council that there is not a sufficient range of appropriate housing options for our consumer group. Again adequate income remains an issue. It is our understanding that all public housing and non-profit housing developments in our county have lengthy waiting lists. Should St Thomas Psychiatric Hospital indeed downsize and realign services to London Psychiatric Hospital, housing and support services will be necessary in the individuals' home communities. I urge this committee to consider these issues as they relate to the health service restructuring implementation plans.

I would now like to speak about specific concerns about proposed changes in the Ontario drug benefit plan. As previously mentioned, the majority of our clients are receiving social assistance or at best supplement their income with part-time or contract work. Dispensing fees and deductible premiums are prohibitive for the seriously mentally ill. It is our experience that many mental health consumers receive weekly prescriptions in order to monitor the effectiveness and to minimize the potential for overdose. Paying a dispensing fee for each prescription would become costly for those on a limited income. For those engaged in part-time and contract work for which there is likely no drug benefit plan, an annual \$100 deduction and additional dispensing fees again would be prohibitive.

It should be noted that psychiatric medication is often very expensive and generally consumers are required to maintain their medication for an extended duration. It's

not like an antibiotic course that you would take for a week or two. It is medication that people are required to take often for the rest of their lives.

We would also like to recommend that consideration be given to extending coverage of non-prescription medications and treatments taken to counteract the unpleasant side-effects of psychiatric medication. For example, sun screens, antacids and even laxatives are necessary but costly, and not currently included in the Ontario drug plan.

We understand that section 13 of the Ontario Drug Benefit Act may be changed to provide that the minister may collect and use or disclose personal information. CMHA Elgin supports Ontario division's belief that all medical information remain confidential and private. This is critical to psychiatric consumers, as they have experienced social stigma and loss of confidentiality as a result of their illnesses.

Proposed amendments to subsections 18(2), (3), (4) and (5) would allow for copayment for drugs, providing different copayments for different classes of persons or drugs. The psychiatric consumer should have equitable access to medications prescribed for them, particularly the majority who are on social assistance or earn too little money to afford annual deductible costs.

Under the proposed new section 22 of the Ontario Drug Benefit Act, the amount paid for a specific product may be agreed upon with the manufacturer. There will be no obligation to decrease the price if the price is decreased in the marketplace. If there are increases in medication costs due to manufacturers' set price and the psychiatric consumer cannot obtain an interchangeable drug, again the consumer may suffer as a result.

The proposed new section 23 of the Ontario Drug Benefit Act is critical to the psychiatric consumer because psychiatric medications may not be clinically interchangeable, and a change in what appears to be similar medication might result in dangerous consequences to the consumer. CMHA, Elgin branch, respectfully recommends equitable access to critical, specifically prescribed medication for psychiatric consumers.

Under section 7 of the proposed new Drug Interchangeability and Dispensing Fee Act, we recommend that the practices under the current Prescription Drug Cost Regulation Act be resumed to the advantage of the psychiatric consumer with a low income who is not covered under the act; that is, substitution of generic drugs for brand names that are prescribed if, under the act, the substitute has been designated as interchangeable with the brand-name product.

Mr Chair and committee members, it continues to be our mission to provide support services to the seriously mentally ill in order for them to live successfully in the environment of their choice with the least amount of professional intervention. We look forward to the government's assistance in this task as the strategies of the economic statement and Bill 26 are implemented.

Mrs Marion Boyd (London Centre): Thank you very much for the presentation. I think it is a very good outline of some of the concerns of consumers in your sector. I've met with a number of them, and certainly you

represent very well the consumer concerns, and I congratulate you on that.

I was a little surprised that you didn't put more emphasis on the records part of the bill, the possibility of the privacy of people's psychiatric records being breached by this act. I wonder if you could comment on what you're hearing from some of your consumers about their fears in that regard. We know that acceptance of service for psychiatric clients is often one of the biggest barriers to their continuing health. Can you describe some of your experience of how that might be a barrier?

Ms Connoy: For those of our clients who become well enough to engage in social activities in our community or educational opportunities and vocational opportunities, they feel their history is their business. When they're applying for jobs and someone says to them, "Where have you been for the last three years?" it's very difficult for them to say, "I've had a major psychiatric disability and I've not been employable."

It's very difficult for people to come to terms with their illnesses, very difficult for them to acknowledge, because of the social stigma and the intolerance of people who don't understand that a psychiatric disability doesn't necessarily mean they are all categorized in the forensic category, or that they are in some way cognitively handicapped to the point where they're not employable or would not be able to maintain a good employment standard. As soon as people state or it becomes known they have suffered a disability, they feel they are going to be disqualified unfairly.

Mrs Boyd: As you went through, I was really struck by what you see as the cumulative effect of the various individual provisions within this act. What you didn't mention was that the cumulative effect—the cost of medication, the proposed merger of the hospitals and therefore a possible loss of service if dollars are applied to the deficit as opposed to being transferred to community care—really come on top of a whole lot of other issues for the clients you deal with.

You remarked that the vast majority of psychiatric patients living in the community are on social assistance. That of course has dropped. Many of the extra supports, the living supports, have dropped because special assistance has generally been deleted from budgets. Can you comment on the cumulative effect of this government's policies on the clients of CMHA in this area?

Ms Connoy: From my particular experience, I work primarily with the case management programs and the residential support programs, particularly rent-geared-to-income housing. Our clients feel that a number of initiatives mentioned by this government are going to impact on them. I've had several calls regarding people's concern that their rents are going to go up and they will be evicted from their homes because they can't pay their rent. They are concerned that if the hospital services go, they are going to be left with no psychiatric support.

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Certainly our agency will pick up as much slack as we can. However, we're more a direct service, more an intervention and crisis intervention. We are not therapeutic and clinical. For a lot of our clients, their experience has only been the St Thomas Psychiatric Hospital;

they have come to that hospital from other communities within the catchment area of St Thomas Psychiatric Hospital. They have not had the support services in their home communities, so when they've been discharged they have then relocated to the St Thomas area to access the services of that hospital. Over periods of years that has become their home, their support system; their doctors and social workers have become their support net. They are very concerned that with the downsizing of the hospital or the realigning of those resources to London, they aren't going to have those supports any longer.

Mr Clement: Thank you very much for your presentation, which mirrored a great deal what we heard from the Canadian Mental Health Association in Toronto.

Let me deal with your comment in terms of reinvesting the savings found as a result of hospital restructuring. I think I can speak for all members that we agree with that point. Talk is cheap, so we will be at least partially judged as a government on how successful we are in reinvesting the savings that occur from restructuring into the community. But that certainly is what the Minister of Health has been talking about, why we need to have the restructuring now rather than put off for another year or two, because we want to plow those savings back in.

To talk a bit about the medical records situation that Ms Boyd mentioned as a concern, we had some discussion at earlier meetings of this committee about that section, how it impacts on mental health patients. There is a section of the Mental Health Act, section 8, which protects and trumps—if I can use that term—other legislation when it comes to patients in psychiatric facilities or in hospitals. I put it to you that they are still covered. Nothing in our legislation changes that.

The concern is valid when it comes to patients in the community. Are you looking for an amendment that would perhaps make anonymous the names of patients in terms of our application of this particular section? There is a deemed-to-disclose medical records section already in the act, but if we strengthen it a bit to make sure that in 99% of the cases we have to deal with there is anonymity for the patient, would that go a ways to alleviating some of your concerns?

Ms Connoy: Our primary concern is that people's records and their personal histories remain anonymous. I'm not criticizing, nor is it my place to judge legislation particularly; I'm not that well versed in the making of legislation. If people want to find out information there's often ways of doing so, but it's our responsibility to ensure that people's records remain as anonymous as absolutely possible.

Mrs Pupatello: I'd like to concentrate on the area of redirected savings into community services. Your organization is on record as supporting this kind of move to services within the community. From an economic argument alone, you are much better able to serve your clientele, with less money, by doing it in the community as opposed to in hospitals.

I want to tell this to the government members, who perhaps haven't been keeping with the minister's statements in the House. I come from a community in Windsor where we've gone through a reconfiguration process of four hospitals to two. We did that on the

advice of ministers that all savings would be redirected into the community for community services. The minister has now reneged on that promise, and that will not happen. The minister is on record in the House—Mr Clement should know this: When asked specifically if saving from the hospital restructuring would be directed back into our community, we were told unequivocally no.

London is considered in other places in Ontario a mecca for health service. You're a teaching hospital centre, you're well funded, you have an adequate supply, if not oversupply, of doctors. When you come from a place like London, I submit that the likelihood of savings being redirected into your community is far less. When Windsor, which is underserved, not a teaching centre, has been told clearly by the minister that he is not redirecting savings into our community, the likelihood is that London, the mecca, likely will not either.

I say that because you've concentrated so much on that, because that's what your clientele needs. It's the best kind of service and it's a less expensive way to address the services your clients need. How does that make you feel?

Ms Connoy: I have a great deal of concern as well. We're from St Thomas, which is 20-plus miles away from our mecca of London. Unfortunately, it's not just St Thomas consumers who would be looking at trying to approach the services here in the London area. It's pretty much the catchment of the existing St Thomas Psychiatric Hospital, which reaches as far as Windsor. It's the small, rural community where there are no support services.

Services need to be redirected, in our experience, with people who have relocated to St Thomas or that surrounding area. They're doing that because they have no support network in their smaller home communities. To some extent, the citizens of our community even feel that somehow they are supporting other people from other localities, which may or may not be factual, but that's the interpretation they have.

There will be a significant cost saving with a realigning of the services from a psychiatric facility that could be reallocated to the smaller communities to ensure that people have the supports they require beyond the psychiatric, medical support.

The Chair: We appreciate your presentation and your interest in our process. Have a good day. Thank you.

NURSE PRACTITIONERS ASSOCIATION OF ONTARIO, SOUTHWESTERN REGION

The Chair: Our next presenters are the Nurse Practitioners Association of Ontario, southwestern region, represented by Carolyn Davies, a member of the executive.

Ms Carolyn Davies: The NPAO appreciates the opportunity to present the concerns of nurse practitioners related to Bill 26.

The Nurse Practitioners Association of Ontario is a voluntary, non-profit association representing nurses working in the expanded role. The concept of nurse practitioners has been in operation over 25 years in Canada. We are registered nurses working in the advanced practice role, oriented to the provision of health care as a member of the team of health care professionals related to families on a long-term basis.

Primary health care includes the initial contact between the client and health care professional, continuing care, and the promotion and maintenance of health. The nurse practitioner is committed to primary health care for individuals of all ages and families in the community. Nurse practitioners work in collaboration with physicians and other health care professionals. Physicians and nurse practitioners complement each other.

Our primary attention is directed towards screening, monitoring, counselling and health education necessary to improving the client's knowledge about health so that we might make informed choices and develop a sense of self-responsibility towards their own health care.

Currently we are working in urban, rural and outpost locations. Many are employed by medical services and function independently in isolated areas. They are also found in urban, rural and community health centres, health service organizations, family practice units, occupational health, ambulatory care, emergency room care, private practice, acute-care settings and educational institutions.

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While the NPAO has always been a voice of progressive reform in health care in Canada, we are concerned that the amendments proposed by Bill 26 will have a negative impact on the health care of Ontario citizens. We are fully aware that reform is needed, but reform based on strategic, long-term planning. In our view, the proposals in Bill 26 will have ramifications down the road that have not been realized without more thorough consideration for long-term consequences beyond the fiscal agenda. This presentation is in support of the RNAO's position on Bill 26.

In December 1994, Premier Harris indicated an important government direction in *Bringing Common Sense to Health Care*. He promised "to empower the consumer of the health care system with the rights to proper care and to participate in decisions regarding that care." This government gave a commitment for public input in the determination of programs and services for the community.

We are concerned that this input has been noticeably absent in the introduction of this bill. The initial push to pass the bill without the opportunity for debate and the difficulty experienced by many members of the public to access these hearings are but two manifestations of this problem. We are very concerned at the absence of critical public debate on issues affecting citizens. With this bill, the government is putting itself at risk of compromising the partnerships and trust built over time between the government and the public. A possible effect is a building of distrust by the voters for the government towards the democratic process.

The NPAO recommends the government consider dividing the act into smaller acts, thereby allowing more discussion. In this way, the government is able to fulfil its promise by granting more opportunity for public participation in critical health care issues.

The NPAO believes the government's energies would be better spent designing, supporting, coordinating and funding a comprehensive health care system. We are most concerned that in its efforts to cut costs the government

is forgetting some of the important elements of the change process, such as appropriate consultation. The NPAO strongly urges the government to consult in a meaningful way with the public and health care providers in its health care reform agenda.

There are several areas we're going to deal with: changing ministerial powers, restructuring, public interest, privatization, user fees and insured services, and health human resources planning. For the benefit of time, I will skip over some statements since you have a written copy.

Changes in ministerial powers: The NPAO acknowledges and supports the government's effort to introduce more quality assurance measures in its provision of health care. We believe this carries the potential to address care problems that may go beyond the power of individual practitioners. Many of our nursing colleagues have witnessed difficulties in delivering optimum care because of inadequate or inappropriate staffing, resulting from unaccountable restructuring.

We are pleased that there will be entrenched recognition of the accountability of organizations. However, we have some concerns about the actual changes in ensuring improved care since there is very little recourse for appeal or consultation prior to decision-making.

Generally, the increase in ministerial powers can be noted for many proposed changes. The minister is empowered to reduce, suspend, withhold or terminate services or funding and accept or reject proposals in the establishment of facilities and services with little or no appeal by the public. The power is poorly defined. There is no description of how these powers will be exercised or their extent or their duration. We support the concern that this much power cannot afford an ambiguous definition. We're concerned that the abuse of power, either intentional or unintentional, could be a possible effect of this strategy.

The NPAO recommends that the minister's powers be defined and terms and conditions be clearly articulated to avoid any ambiguity. Furthermore, we urge the introduction of a sunset clause to ensure that powers are appropriately limited.

We get a sense that the proposed expanded powers tend to move the government into a more micromanagement role in some aspects of clinical decision-making. We support the belief that the government's energies are better spent in designing, supporting, coordinating and funding a comprehensive health care system. There is no question that the government plays a critical role in assisting and guiding the public and providers to determine the appropriate health care services for each community or region. But we are very concerned that in its effort to cut costs, avoid duplication and increase efficiency, the government is forgetting some of the important elements of the change process, such as appropriate consultation. Some of the possible effects might be that the needs of health care consumers will not be met adequately or appropriately in relationship to the uniqueness of the community.

NPAO recommends that the government continue to consult with the public and health care provider groups in its health care reform agenda.

According to current legislation, the minister has the power to determine fraud and to investigate. These powers already have implications for compromising privacy or confidentiality of records. Health patient records are highly confidential and access should ideally be restricted to the client, the health care provider, or a specified and regulated review such as an OHIP investigator.

However, Bill 26 contains provisions that will allow the government unprecedented access to personal records. We don't argue that the government has the right to investigate fraud within the system, but we believe that these increased powers of access and disclosure are unnecessary. The opportunity for unnecessary breach of confidentiality is enhanced when more individuals have access to confidential data. Furthermore, the government's freedom to disclose information with any party it chooses is trouble because of the potential loss of control to organizations that may be beyond Canadian governance. Possible effects might be that these powers cause very ill people to avoid seeking help and prevent practitioners from fully charting findings on the charts.

NPAO recommends that the appropriate criteria for accessing patient records-health information be clearly delineated and strictly enforced. There also needs to be consistency with the Freedom of Information and Protection of Privacy Act. NPAO also recommends that whenever the government deals with external agencies or organizations there exist clear criteria regarding the control and protection of confidential information.

In several sections of the bill, the government or its delegates are protected from liability. For instance, some of the proposals are couched in such terms as the government cannot be held liable for "any act done in good faith." Bringing Common Sense to Health Care emphasizes the importance of accountability at all levels of the health care system. We do not believe this double standard proposed by the government to be acceptable, and a possible effect in the case of accidental disclosure of confidential information is that the government will not have to be held responsible or accountable. Government will lose its credibility with the voters.

NPAO recommends, as a necessary and critical connection in the health care system, that the government must be held accountable for all its actions. We suggest that criteria and guidelines for some of the minister's intended actions be clearer to avoid ambiguity and chances for error. NPAO recommends that in the interest of the public good, alternative mechanisms should be instituted to facilitate an appeal process.

The second area we have looked at is restructuring.

The Ministry of Health Act allows for the establishment of a province-wide Health Services Restructuring Commission to carry out duties assigned by the minister. While the commissions's role is to "facilitate and accelerate the implementation of hospital restructuring," it appears only to address the restructuring of the hospital sector. Reform that addresses only one sector at a time will encourage a fragmented rather than an integrated health care system. Possible effects are that the health care resources in the community will not adequately meet

the needs left by changes in the hospital structure. Services will be fragmented.

NPAO recommends that the role, mandate and terms of reference of the restructuring commission be clearly articulated to take other sectors into consideration and to avoid public confusion and critical gaps in care.

The NPAO supports other bodies in the concern about the possibility of service gaps that will compromise the health of Ontario's citizens. The definite plan to accelerate the process concerns us. We believe that changes that occur in hospital services must reflect changes in community services and health care practices and vice versa. Recent trends clearly indicate that community support services must be available and in sufficient number to support hospital restructuring. For example, the reduced length of stay in hospitals increases the need for home care support services for medically complex patients. The increased use of ambulatory care centres also increases the need for accurate assessments both pre-admission and pre-discharge.

The trends to deinstitutionalize patients in order to care for them in the home and the use of more volunteer labour must be addressed before province-wide restructuring begins. This dependency on volunteers requires a more flexible, educated and knowledgeable workforce that can quickly assess changing circumstances in a client population. If these service gaps are not addressed first, we believe that more suffering will be experienced and more money spent due to complications of inadequate care. A possible effect is revolving-door hospital care due to inconsistent voluntary care and understaffed community response.

1020

The NPAO recommends that changes in non-hospital sectors such as long-term care must not only be identified but that strategies for implementation must be clearly articulated and resources committed to these activities prior to the implementation of any system-wide hospital restructuring program occurs.

The restructuring commission is ready to start work as soon as the bill is passed. However, restructuring has occurred at different rates in all regions across Ontario. In Bringing Common Sense to Health Care, the public is identified as a key player in determining local community health care priorities. The NPAO agrees that there must be an opportunity for each community to discuss and voice its needs for successful province-wide restructuring to occur. The current district health council structure enables this type of public participation to occur. Possible effects are that different regions will on one hand not have their health care needs met and on the other hand will have health care imposed on them that they do not require.

The NPAO recommends that the commission continue to work with the existing district health councils to allow for planning and decisions about regional health service needs that are sensitive to community differences.

The proposed legislation states that the commission members from the health sector, business and the broader community are to be appointed by the ministry. We support the belief that it is important to have nursing representation on this commission. Nurses are active

participants across the entire spectrum of health promotion and care provision. This expanse and scope of experience is critical to any comprehensive health care planning and restructuring. We recommend registered nurse representation on the restructuring commission.

The third area is public interest.

The NPAO supports the concern that this proposed legislation contains the frequent use of the expression "public interest." The minister is given powers to reduce, spend, withhold or terminate funding to hospitals if it is in the public's best interest. While we commend the government's intent to determine services and funding in consideration of public welfare, the concept is not well defined. Who determines public interest? Whose value system defines public interest criteria? The term "public interest" is also inconsistently applied.

While this term is used extensively throughout the Public Hospitals Act to rationalize the minister's power to intervene, for example, while we recognize that the public interest is a changing reality that depends on specific community values, there must be province-wide consistency in closely considering public interest. An effect we are concerned about is that the citizens of Ontario will perceive the government to be paternalistic in using a undemocratic decision-making process.

The NPAO recommends that "public interest" be clearly defined and that there be a consistently applied rationale underlying all health care reform.

The fourth area is privatization.

The amendments of the Independent Health Facilities Act may well challenge our universal, accessible, publicly administered health care system in Ontario by creating an environment that allows more privatization. Proposed amendments in section 7 repeal the language that directs the minister to give preference to non-profit facilities and protection or priority to Canadian-based proposals, which will encourage proposals from for-profit, non-Canadian organizations. Although this signifies the government's receptivity to foreign firms entering Canada's health care market, we are doubtful that the majority of Ontarians share this view.

These amendments increase the opportunity for conflict of interest and enhance the potential for a two-tiered health care system that argues that those who are willing to pay for services will be allowed this choice. However, considerable data indicate that a two-tiered health care system is not only more costly but can also leave millions of citizens without equal access to services. The NPAO believes strongly in preserving the Canada Health Act and the Canadian health care system. A possible effect is that Ontario will develop a more Americanized, costly health care option and in many cases receive unnecessary procedures for a privileged few.

NPAO recommends clear directions, guidelines and control to ensure that non-Canadian corporations and organizations meet the standards integral to the Canadian health care system. Mechanisms such as quality assurance controls must be essential aspects of this contract.

The fifth area concerns user fees and insured services.

Despite election campaign promises not to introduce user fees, the proposed medication copayment under the Drug Benefit Act is fundamentally the introduction of

user fees. These fees have several ramifications for social assistance recipients and seniors receiving guaranteed income supplement, who will now be required to pay an annual deductible fee and all dispensing fees. We are in effect punishing the elderly and disadvantaged for being ill. Furthermore, the human cost of this policy will have a tremendous cost on children and families. User fees and copayments will not reduce the need for prescription drugs but will reduce the number of prescriptions filled by individuals and families on limited incomes. We believe that when confronted with these extra charges, individuals will be forced to choose between food and medication.

We are convinced that instead of saving money, this particular approach will result in greater expenditures. The complications and side-effects suffered by those unable to afford the needed medication will be even more expensive to treat. This move will take the health care system back to the 1950s when people were not able to afford the cost of care and got so sick before seeking treatment it was costing the system in hospitalization and in the critical rather than primary care stage.

The issue of drug use needs to be addressed in a way that does not disadvantage those in greatest need. Rather, the health care practitioners need to take more responsibility to review prescribing habits that reduce the unnecessary use of prescription drugs.

The NPAO recommends that government address the issue of proper drug utilization programs as opposed to charging fees as a solution to the rising costs of the drug plan.

Under the proposed subsection 4(4) the government will no longer pay differences between what are considered interchangeable products, even if the prescription calls for no substitution. This means that if the individual requires a specific drug no longer paid for by the plan, they will have to pay the difference.

While the NPAO supports the principle of interchangeability, in practice this is not always feasible. A cheaper drug may not be a possible alternative. Some individuals experience adverse effects to non-therapeutic components of the generic components. There is a mechanism in place now where the health care practitioner may apply for approval for brand-name drugs to be used. We encourage the government to allow the individual needs and differences to be considered in developing drug policies.

The possible effects are that those patients unable to pay higher costs of non-generic drugs may not fill their prescription and the resulting increased costs of untreated illness will be passed on to taxpayers through the cost of hospitalization.

The NPAO recommends that the government consider alternatives to the generic approach such as the BC drug plan, which considers not only generic substitutions but also therapeutic substitutions.

Within the Health Insurance Act changes, the minister is now able to determine that insured services are unnecessary. This means that services can be removed from the OHIP schedule of benefits at the minister's discretion without consultation. This has significant implications for the status of Ontarians. Those who can afford it will be

able to obtain these delisted services. Furthermore, this government promised Ontario citizens that OHIP decisions would no longer be made behind closed doors and would include public input. We are concerned that the government is taking a path that will inhibit rather than enhance public input and are concerned about the erosion of the public input into the decision-making process related to health care issues.

The NPAO recommends that any changes to insured OHIP services and benefits be made in consultation with health care providers and through public debate. Changes must be made recognizing the diversity of needs, values, culture and socioeconomic status.

Number 6 is health human resource planning.

Under the Health Insurance Act, section 29.3, the government proposes by regulation to "fix or vary number of physicians, or the number of physicians in a class of physicians, who may become eligible physicians in an area" and so forth. Similar physician resources management is evident in the Public Hospitals Act and schedule I, Physician Services Delivery Management Act, 1995.

The NPAO supports other health care professional groups in their position complementing government attempts at health care resource management, though we feel its energy should be focused more widely instead of micromanagement. The NPAO recognizes that there is an uneven distribution of medical specialties and an overabundance of some specialties in urban areas and fewer in rural areas and northern communities. However, we are concerned that these amendments will not resolve the issue of health resource planning. Rather, they are a Band-Aid solution to a critical distribution problem.

The issue of supply and demand and distribution of health care providers has been a discussion in health care for some time. The nursing profession has experienced the fluctuation with the need for nurses. Graduates of 1995 are extremely underutilized, with restructuring of all sectors of the health care a principal cause. This in itself is a waste of taxpayers' dollars. As with nurse practitioners, many nurses are not only not used to their full scope of practice but are being lost to downsizing. This costs all Ontarians.

1030

Long-range health human resource planning must be part of a larger picture of health care reform. As part of the integration into the economic formula, this planning of the health care industry is essential. This kind of planning takes into consideration the present and future health human resource requirements and uses health care needs as the starting point. Once these needs or goals are identified, issues such as the numbers educated and distribution can be appropriately assessed. This way, not only will there be a better sense of the numbers required, but we will also be able to more accurately assess the needs for and distribution of certain types of specialist. If we are to have a well-planned health care system, we must aim for a flexible, innovative health care provider workforce capable of providing quality, cost-effective health services to meet population needs.

The NPAO supports the belief that while alternatives, such as incentives, improvement in conditions and differential remuneration, help in some of the shortages

of practitioners in some areas, an established system-wide health human resource planning would alleviate these persistent problems in service delivery in the long term.

Possible effects: A system-wide planning approach would assure an appropriate mix of health care providers to meet population needs.

The NPAO recommends that system-wide, comprehensive and integrated health human resource planning be initiated.

Finally, the NPAO believes that it's logical and efficient that practitioners practise according to their full scope of practice. We, as nurse practitioners, are one notable example of underutilization in the health care system. Freeing the nurse practitioner to provide care according to his or her full scope and ability allows the medical practitioner to attend to more complicated medical problems. This reduces the pressure on the health care system to provide appropriate care for consumers and allows the medical practitioner to attend to more complicated medical problems. The public can only win in a situation in which the appropriate provider is able to give the care he or she has the skill and expertise to provide. The nurse practitioner is cost-effective, provides quality, adequate care and has a high level of consumer satisfaction.

NPAO recommends changes to the Regulated Health Professions Act, thereby allowing the nurse practitioner to practise according to their full scope of practice.

In conclusion, the NPAO appreciates the opportunity to speak to these very critical issues on health. While we recognize the government's commitment to fiscal reduction as mandated, we are very concerned that this proposed legislation as it stands not only goes far beyond the platform of the past election but will put the progressive changes in health care reform at risk.

We believe that public hearings such as this are critical to the wellbeing of democracy, but these hearings represent only part of the democratic process. The opportunity for public input alone offers few guarantees. There must be an accompanying commitment on the part of government to carefully take into consideration the voices of concerned citizens and consider that input. We ask the government to remember its role in the democratic process of change with the people of this province.

Mrs Janet Ecker (Durham West): Thank you very much. You make a recommendation about, "Mechanisms such as quality assurance controls must be an essential part of any contract." The Independent Health Facilities Act, under which this would be done, does have that in it. Nurses have been involved in making those quality assurance decisions as part of the teams with physicians. Do you believe the quality assurance provisions in the Independent Health Facilities Act are appropriate and would they suffice for continuing to do that with the clinics and the facilities?

Ms Davies: I think that we have to make sure that we're getting across-the-province input, that health care professionals at all levels are being consulted, not only particular groups, and I do think that yes, we need to continue on with consulting with the health care providers in the progress of the health facilities act.

Mrs Pupatello: What consultation have you or your organization had with this government?

Ms Davies: We have only had some minor invitations with the Minister of Health to talk about the nurse practitioner initiatives and the direction that we will be going with expanding the Nursing Act.

Ms Lankin: Mr Chair, I'm genetically incapable of asking a question in 30 seconds. So let me thank you for your presentation and let you know that a number of the areas that you raised are areas of concern that we as a caucus have and that we will be putting amendments forward on, and hopefully, if we can see the amendments from the government in the next day or two, we'll have an opportunity to assess whether any of your concerns will be met or not.

The Chair: Thank you, Ms Lankin; I appreciate your honesty. Thank you for very much for your presentation this morning.

We're going to have a quick three-minute recess before our next presenter, who is Megan Walker, a councillor from ward 6 here in London.

The committee recessed from 1037 to 1040.

MEGAN WALKER
LONDON AND DISTRICT
ACADEMY OF MEDICINE

The Chair: Okay, we now have Megan Walker, and the London and District Academy of Medicine: Dr Larry Patrick, Dr Fred Sexton and Dr Denise Wexler.

Ms Megan Walker: My name is Megan Walker, and beside me is Dr Larry Patrick, who is the president of the London and District Academy of Medicine. Beside Dr Patrick is Dr Fred Sexton, who is the vice-president, and at the end of the table is Dr Denise Wexler, who is the past president. I was given a time slot to appear before you last week and contacted Dr Patrick to seek some clarification and advice. At that time he notified me that the London and District Academy of Medicine had not been given a time to speak, and as a result of that, I have presented my submission in writing and have given my time today to the academy of medicine. I hope you will take the time to read my submission, and if you have any questions or concerns, please feel free to contact me, but at this time I would like to turn the floor over to Dr Patrick.

Dr Larry Patrick: Thank you very much. Mr Carroll, just as a backgrounder, I'm an internist at Victoria Hospital, Fred's a family practitioner in town and Denise is a dermatologist. We ask the committee to please listen, because we feel that certain provisions in Bill 26 may actually cost lives.

Mr Chair, members of the committee, usually at this point I would be thanking you for the opportunity to present here today. However, it is apparent that the sincerity of this process we are undergoing here today is in question, considering that the local medical academy, which represents over 1,500 physicians in London and the district, was not given an opportunity to present today. I'd like to thank Megan Walker for offering to share her time with us, although it is less than a satisfactory solution. As well, we recognize that the committee

has a very difficult job due to the very limited time made available for you to assess the information collected before the line-by-line review of the bill prior to the third reading beginning on January 29.

Physicians have always been willing to cooperate with government when it is in the patient's best interests. Although we feel strongly that the proposals in this bill are not in the patient's best interests, we would like to continue a working relationship with the government that works towards achieving the best-quality patient care possible.

Canada—and Ontario—is said to have the best medical health care system in the world. This system has always been based on a working relationship between government and physicians, and now the system is being dismantled and physicians are being shut out of the decision-making process.

Dr Fred Sexton: This bill would allow the decision as to the necessity of medical services to be determined by a bureaucrat rather than a physician. Second-guessing of medical decisions by a bureaucrat based on outcome carries such dangers that one can only fear the reduction of care to patients.

As an example, let me tell you of a patient who had a severely damaged foot. The first surgeon who saw the patient recommended amputation. A second surgeon, consulted at his request, offered to try to save the foot with a complex operation which had a small but a very real chance of success. After some time and expense, the attempt failed and the foot was amputated.

I suggest that this type of situation could result in the surgery being declared medically unnecessary or inappropriate and the physician asked to repay all fees associated with this under this current bill. Two things would certainly occur: the cheaper and less expensive therapies would be promoted and a new, riskier but potentially better therapy would be avoided.

A second example would be the patient who presents in the doctor's office with an episode of chest pain. The doctor would be obliged to distinguish the aetiology of the chest pain, which would cause him to do electrocardiograms and perhaps blood tests to eliminate a possible heart attack. When that chest pain eventually turned out to be nothing other than heartburn, the physician would be obliged to repay the cost of the cardiogram and the blood work under this current bill, as it was in fact medically unnecessary for the condition treated.

A physician who is subjected to this type of bureaucratic decision-making won't take any chances and won't try anything new. Who would you rather determine necessary medical procedures: the regressive Conservatives or your physician?

Dr Denise Wexler: Why are so many physicians leaving Canada? Doctors are leaving this province, not, as believed, for higher incomes, but for the freedom to be a respected professional. Last night we saw a list of doctors who had left the province from the Thunder Bay area and within five minutes we had drawn up a list of doctors who have left the London area. We have a list of 26 physicians, and I'm sure this is only the tip of the iceberg. If Bill 26 is passed in its present form, I'm sure it will only add to this exodus. The frightening thing is

that from London alone we have lost four orthopaedic surgeons, two neurosurgeons, two intervention cardiologists, one radiation oncologist. All of these people are already in short supply and are very hard to replace, so it's not like we can just go out and find a body.

It has been said that 90% of new graduates in the Toronto family practice program will leave as well if the bill goes through. We must not forget that the USA can easily absorb the total output of our Canadian medical schools for the next 10 years. In particular, there's a great demand for family physicians in the United States. They have always recognized the superior system of primary care that we have in Canada.

In 1986, the government agreed to pay increases in CMPA fees in lieu of fee increases. Bill 26 proposes to end this payment, causing grave concerns for the availability of health care. This committee has already heard about the difficulties that this change will make for the delivery of obstetrical care across Ontario. As well, however, we have concerns about the availability of a number of other specialty services. To name only a few: neurosurgery, orthopaedic surgery, cardiovascular surgery, plastic surgery, general surgery. So all of us here, if we want our brain tumour removed, our hip replaced, or perhaps even our appendix removed, had better do it quickly while these doctors are still in Ontario.

Dr Patrick: With Bill 26, the government proposes to restrict new billing numbers to those geographic areas deemed underserved by the government. This will dictate to all our new medical graduates areas where they must live and practise. I'd like to have you consider, if you will, a family member—a brother, sister, son or daughter—who has just finished an intensive post-graduate medical training and with this bill will be forced to go to a geographic area that may not be in their best wishes or, for that matter, they possibly may not be trained to go to that area.

Dr Sexton: Retiring physicians from one of the 12 so-called overserved areas of the province, which includes this London area, will not be replaced. I'm sure that many of you here today have felt the frustration of trying to find a new family physician. This bill will further interfere with the continuity of care.

Another proposal in Bill 26 is the tying of billing numbers to hospital privileges. This means that a physician must have hospital privileges to bill OHIP for services provided. With the coming hospital amalgamations and closures, many physicians will lose their billing numbers and be unable then to practise. With Bill 26 there will be absolutely no appeal process for these physicians.

Dr Wexler: In the so-called best health care system in the world, it can take up to seven months to get an appointment for back surgery, 14 months for elective hip surgery and over two years for specialized ankle surgery. Before I came here, I saw a few patients and the last patient that I saw was a 15-year-old girl. She had damaged her knee a year ago, skiing. In July she had arthroscopy. The procedure was successful but she was left with a tender lump on her knee. She is now unable to participate in sports without pain, has some difficulty in daily activities because of pain limitation. She went back

to see her physician. He booked an MRI—this was in November—however, this will not be available till February, and she won't see her doctor again until March. So we're probably talking about a two-year span.

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However, fortunately I was able to give her a hot tip, because this was in the *Globe and Mail* last week. Basically, there's a 1-800 number for the University of Virginia Medical Center, and if you call this number you can begin making arrangements to receive your new hip, your knee or whatever surgery you need within a matter of weeks. Surely, there's something wrong with our system. I think people would be willing to pay to be pain-free and functioning with little delay. This might even set us up in a bad situation where we might pay for inappropriate care. So all around, it's a terrible scenario.

Dr Patrick: Physicians know it's time for a change, but let's not throw out the baby with the bathwater. Rather than tearing up the agreements with the OMA, this government should recognize that the OMA represents the physicians of Ontario and they must be included in the future administration of this health care system. We are very sceptical as to whether Bill 26 will even save money. We have not seen any proposal of the cost implications for all of these inspectors and bureaucrats that this bill seems to mandate.

Dr Sexton: A local MPP was quoted this weekend as saying that 99.9% of doctors are honest and hard-working and that the provisions in Bill 26 are needed to catch those 0.1% who are overbilling the system. Has the government considered the cost of this added bureaucracy, an infringement of doctor-patient confidentiality, to catch these 22 physicians across the province? Couldn't we devise a better method to deal with these rare individual cases than this current piece of dictatorial legislation?

Dr Wexler: In conclusion, on behalf of the 1,500 physicians whom we represent, we would like to stress that although we cannot agree with Bill 26 in its present form, we are willing to work together with the government to provide the best possible health care for the people of this province, because we realize that physician input is vital to the success of the process.

Mr Bob Wood (London South): I think this submission makes some very good points, and I don't think the issue on the question of review is whether or not there's going to be a review; obviously, when the government spends the many billions of dollars it does on health care, we have to make sure we're getting value for the money that's spent. I think the issue is, what's the right mechanism of review for the money that's spent?

You have before you what's, in effect, peer review. It's going to be done by doctors. They're going to look and make sure that the services billed have been medically necessary. Of course, the decision's going to be made by the physician and the patient. How would you do peer review to avoid medically unnecessary procedures or fraud?

Dr Wexler: We already have a system in place with the College of Physicians and Surgeons. It could perhaps be expanded so that there are not only physicians represented in the peer review process but some of the lay

people at the college are also involved in the process. That might help solve the problem to some extent of the fact that it's just physicians reviewing physicians.

Mr Bob Wood: How is that different in principle from what's in the bill?

Dr Patrick: One of our problems with this bill is the fact that physicians don't like governments—

Mr Bob Wood: Lots of others don't, too.

Dr Patrick:—and this bill is not making that any better. We have a feeling that politicians, and you probably don't, have a vested interest: bean counters, outcome analysts. There is a process that I'm sure we could work out that would not appear to be as heavy-handed or as interfering as this current piece of legislation. All you're going to do is piss us off even more.

Mr Bob Wood: We're not interested in doing that. I'm not sure I see a major difference between what you folks are saying and what's being proposed in this bill, provided it's done properly. A bad review system is a bad review system; no doubt about that. I think the system that you're proposing and what we're talking about is really quite similar.

Dr Wexler: I think the major difference is that you're talking about having a government bureaucracy or government officials go in and look at doctors' practices; the system that is in place now through the college has physicians involved. Physicians would be totally out of the loop as the situation is to be set up in Bill 26.

Dr Sexton: There is another difference that I think is really critical, Bob. The assumption that most people would make is that we know what appropriate medical treatment is at some point in the process, and if one looks retrospectively at what was appropriate, if you look backwards at what the government has suggested as the outcomes, it mirrors what I talked about with the chest pain. Once we arrive at a diagnosis, it can become quite apparent that unnecessary tests were done, but looking from the point of time that the physician looks at it, it is a medically necessary test to eliminate possibly life-threatening disease conditions.

If we look in the end at what we eventually arrived at and say, "Those tests that were done along the way now appear to have been unnecessary" and the doctor will be responsible for those, that will be a decision that will be a Gordian knot. We don't have that answer, but I do believe those are the kinds of standards we talked about developing through ICES and through further negotiations with government.

Mr Bob Wood: I think certainly the minister has made it quite clear. This is not a matter of second-guessing people at a later date. This is a matter of looking at what was done and determining whether or not that was reasonable in the circumstances.

I'd like to go on to one other point because time is limited. The physicians have come up with a plan that they think will solve the problem with respect to underserved areas, and the minister has made it quite clear that if that works, that's the end of the matter and the physicians' plan will be accepted and nothing further is going to be done. Do you have confidence that this plan is going to work?

Dr Patrick: Dr Jim Rourke from Goderich will be addressing this issue this afternoon. He has some plans that will involve underserved communities, the universities, and in fact he'll point out to you that Ontario—and probably Canada—is about 10 years behind the United States in encouraging young physicians to go to underserved areas. This is a problem that we've not got into overnight, and we're certainly not going to fix overnight.

Mr Sergio: Thank you for a good presentation. I enjoyed it very much, especially your frankness as to what you think of the content of the bill and politicians, if you will. When we are presented with such a piece of legislation, I don't blame you for thinking that way.

Let's get back for a moment to the intention that you have in providing and delivering the best health care to our people. As the bill as presented to us says that the minister has all the power to say what kind of care and who is going to get the type of care, are we moving to a two-tier system? Are we leaving universality as we know it here in Ontario? If that is the case, how are you going to deliver the best possible care to our people?

Dr Wexler: We already have a two-tier system in Ontario. People who want their cataracts fixed and don't want to wait will go to the United States if they can pay. People who want hip surgery will go to the United States. So we have a two-tier system. It's just that people leave the country.

Mr Sergio: What about universality as we know it?

Dr Wexler: As it is at the present time, everybody has access has access to a certain standard of care, but that may not be the standard that everybody wants. I couldn't work as a dermatologist if I couldn't see, so if I developed cataracts, I don't want wait a year and a half to get my cataracts fixed. You might not want to wait a year to get your hip seen.

Mr Sergio: But when we have the minister that says you can only provide specific services to specific areas and specific people, then are we really providing the best possible service to our universal population, those who can and those who cannot afford it?

Dr Wexler: Probably the best possible.

1100

Dr Patrick: We understand money is short and we can't do everything and be everything to everyone. That's not possible. It wasn't possible 10 years ago, it isn't possible now, and if the government's going to get out of trouble in the next two years, we're going to have to really crunch down on the system.

Mrs Pupatello: Dr Wexler, you asked about a willingness to pay—what would we be willing to pay to be pain-free and functioning, with little delay?—and you held up that ad. That's what's written, but what you said was people would be willing to pay. So you're advocating a two-tier system within Ontario.

Dr Wexler: I'm not. I'm saying people would be willing to pay to go to Virginia. That's all I'm saying. And I'm sure they will get some responses to that ad.

Mrs Pupatello: Is the purpose of doing that so that then we should change the system so that people can pay in Ontario, stay within our borders and have that service provided and so have a two-tier system in Ontario? Is that what you advocate?

Dr Wexler: That may in the end make the most sense, but right now we can't do that because of the Canada Health Act. An individual province, as I understand it, can't just make a decision to bring in two-tier medicine.

Mrs Pupatello: So would you advocate jumping the queue then for those who can pay to access surgery in a quicker manner?

Dr Sexton: You're going down the wrong road with this, Sandra. What we're trying to say is this: Basically what this act did was it created a situation where the United States could, first of all, come in and rape our country of its best young medical minds, its best young physicians. We've said that 90% of these physicians are going to go to the United States because of the repressive nature of the health care atmosphere here.

The secondary point that we added to that was that this same bill allows the exploitation of people who are in pain and have specific medical needs, because the system can't meet the needs. These are people whose needs are so great that they would make a financial sacrifice. We did not make any point other than that they were about to be exploited by the United States system.

Ms Lankin: Thank you very much, councillor and doctors. We appreciate your presentation. One of the concerns I've had about this bill is, I believe that it's poorly understood by a lot of people, including a lot of members of provincial Parliament.

With all due respect, I must say to Mr Wood, his understanding of the changes around assessment of medical necessity by the general manager of OHIP is completely and utterly wrong. This bill is a fundamental change from the past, where if there was any concern about a doctor's billing, the general manager of OHIP would refer it to peer review under the College of Physicians and Surgeons. The medical review committee would look at that, in consultation with the practitioner, and try to determine whether or not there had been some inappropriate billing that had taken place, and make that recommendation back to the bureaucracy.

Now you have the bureaucracy, not a professional, not any kind of peer review, making second-guessing decisions about whether or not what a doctor has ordered in terms of treatment for his patients was in fact medically necessary—a fundamental change in the power structure.

Mr Bob Wood: Do I get a minute to refute this?

The Chair: No.

Ms Lankin: I think it's very important that we understand that there are people who are going to be voting on this bill who don't understand what in fact their government is doing.

Dr Sexton, let me put this to you. In the brief you talk about issues of hospital privileges and billing numbers. There's another aspect to hospital privileges in this bill that is of concern to me. You're right that under a hospital closure there can be a complete revocation of hospital privileges without any appeal, and in terms of where those doctors go in the system, you raise a legitimate concern.

But there's another new addition in this bill which says the minister can set out any other reasons, other than closure, under which revocation could take place, and set out whatever procedure or no procedure that the minister

wants and bypass all of the due process protections that are there.

We've heard from physicians about their role of patient advocate, for new technologies, for appropriate budgets, for certain disease-centred areas of treatment, how sometimes they're a thorn in the side of hospital CEOs, and the chilling effect this will have on that patient advocacy role if a doctor believes that a CEO can just unilaterally revoke privileges. Can you comment on that? Is that a reasonable concern for physicians?

Dr Sexton: There's a high level of anxiety here in London with hospital restructuring going on, and that's quite pertinent to the types of possibilities that could come here within the next year or two. Different types of practice may be localized in one hospital or another hospital, and this would of course leave certain physicians without a practice; it would leave them without a billing number and no means of appealing the process. When they're without a billing number they will not be able to practise in London any longer. That also should be regarded as an abruption of the continuity of care to the patient. That physician basically has no ability to maintain a continuity of care, London being designated as an overserved area.

Dr Wexler: The other issue, though, is that many physicians do not have any connection with hospitals and I'm not quite sure where this came in. To tie billing numbers to hospitals makes no sense at all. Some physicians would not ever use a hospital. For those physicians who are in hospitals, they are always jockeying back and forth with the administration about trying to get equipment and staff for their particular section, and this could end up in them losing their privileges, their billing numbers, and they're gone.

Ms Lankin: In fact, if you believe in the move from institutional care to community care, and this has been pointed out to us, for example, in terms of community psychiatry, that's an important shift in the practice of psychiatry that's starting to take place and those people don't need to have any relationship to a hospital and yet now they will have to. With the minister being able to impose physician human resource plans on hospitals there are a lot of unanswered questions. One of the concerns I have—and it was best put by a presenter in Thunder Bay who said: "The government is asking us to give them a blank cheque. The problem is, they're not telling us what number they're going to write in before they cash it." Do you have any comments in terms of, do you know how the minister intends to use these new provisions around revocation of privileges? Do you know how he intends to handle doctors who are community-based and not hospital-based in terms of billing numbers? Have you been consulted on that?

Dr Patrick: We haven't been consulted but he has said we should trust him.

Ms Lankin: You're a bit sceptical, I think.

Dr Patrick: I don't even know him, so why should I trust him? The other part of the problem is, if he thinks this bill is so good, why has he removed us from legal due process? If someone has been arbitrarily removed from hospital staff, this bill says that individual has no due process in law to be able to complain to anybody.

This is blatantly unfair. This is picking out a group of individuals and saying: "You people are going to pay for this one way or the other. Either professionally or financially you're going to pay."

The Chair: Thank you very much, doctors, and I want to add my thanks to Megan for giving up her time for the doctors; we appreciate that.

ONTARIO ASSOCIATION OF OPTOMETRISTS

The Chair: The next presenters are the Ontario Association of Optometrists, represented by Dr Richard Kniaziew, the president. Welcome to our committee.

Dr Richard Kniaziew: Greetings. Let me begin this morning by introducing myself, my colleagues, our profession and the organization I represent. I am Dr Richard Kniaziew, president of the Ontario Association of Optometrists. With me today to make this presentation is Dr Mira Acs, our past president.

I will try not to take up all the generously allotted time, but I'll take a moment to explain who we are and what we do. The Ontario Association of Optometrists is a voluntary membership association representing more than 90% of the approximately 1,000 active licensed optometrists in Ontario.

Optometry is an independent, self-regulating, primary health care profession with a long and successful history of self-regulation. Ontario passed its first Optometry Act in 1919 and the current act, which is part of the regulated health professions legislation package, in 1991.

In the past decade, optometrists provided more than two thirds of primary eye and vision care services in Ontario. Optometrists are university educated, clinically trained and provincially licensed to assess, diagnose, treat and prevent diseases and disorders of the eye and visual system.

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Provincial legislation provides the framework for optometrists' professional responsibilities and for their accountability. The Regulated Health Professions Act, the Health Insurance Act, the Health Care Accessibility Act and the Optometry Act are the principal pieces of legislation governing optometric practice.

The Ontario Association of Optometrists, incorporated in 1909, is the voluntary professional association authorized by the Health Care Accessibility Act to represent Ontario optometrists.

The College of Optometrists of Ontario has been given the task of ensuring that high professional standards are maintained through their quality assurance programs, through adherence to published standards of clinical practice and through strict enforcement of regulations and guidelines by such committees as the optometry review committee, which reviews the OHIP billings and the patient records of individual optometrists who have been referred to them by the general manager of OHIP. The College of Optometrists of Ontario has taken a leading role among professional registration bodies in Canada in establishing written standards of practice. The Guide to the Clinical Practice of Optometry published by the College of Optometrists of Ontario is regarded as the primary reference for standards of optometric practice. Since 1972, this guide has been revised three times.

The Health Insurance Act provides for the payment of most optometric diagnostic services under two billing codes. Additionally, optometrists are permitted to provide non-OHIP-insured treatment services to their patients. Like the physician or dentist providing non-OHIP-insured therapies, the optometrist charges a professional fee for providing these services. Such is the case with the provision, for example, of spectacle therapy or low vision therapy.

Now we come to the reason for our being before you today, Bill 26, the Savings and Restructuring Act. Optometrists are not strangers to abrupt and surprising announcements on health care services and funding by the Ontario government. Despite the value of the services we provide, we are all too frequently informed by the Ministry of Health of important health announcements after the fact or by reading them in the Globe and Mail. So the abruptness of these announcements was not new or shocking to us. What we did have trouble comprehending was the breadth and sheer volume of the proposed changes. While most of these changes do not specifically address the profession of optometry, they are fraught with implications for the future viability of our health care system, and as responsible providers we must participate in this process.

Partly because of the scope of the announced changes, our inexperience with certain elements and the brief time we have had to prepare ourselves, our remarks today will be confined to selected issues only.

Dr Mira Acs: So in no particular order, then, we refer to schedule H with its proposed amendments to the Health Insurance Act and the Health Care Accessibility Act. We are most concerned with announced changes allowing the Minister of Health to collect, use and disclose personal information, beyond what is currently provided for in the existing legislation, concerning insured services provided by physicians and other health care providers. We are not convinced this is necessary, and moreover we are sure it violates patients' basic rights to privacy of their personal health information.

With respect to the proposed amendments which affect the supply and distribution of physicians, one word describes our reaction: "Wow," followed up by a big question mark. Are these measures really necessary?

We know that physician manpower has been the subject of intense discussion and debate in recent years. It was because of restrictive measures to control physician numbers, proposed by the former government in its 1993 expenditure control plan, that the Ontario Association of Optometrists negotiated a manpower review process under our social contract agreement which is just now finishing a 12-month joint manpower exercise with the Ministry of Health. I hope we are not being naïve if we assume that staff recommendations to the minister concerning this profession will be discussed with us first and perhaps may even be joint recommendations.

We understand and are sympathetic to the minister's concern with controlling expenditures for physician services, and we have read reports of many communities that are medically underserved, but the list of amendments in schedule H to permit the government to, in its words, better manage the supply and distribution of

physicians is too restrictive, too far-reaching and removes too many of the basic freedoms that all self-employed people in Ontario have come to expect. I believe the minister has stated that he will hold off proclaiming these sections and will wait to see if new incentives help to improve distribution of physicians. We strongly encourage him both to hold off on these measures and to work out a long-range plan in cooperation with the medical profession.

Amendments with respect to physician OHIP payments in schedule H directed at defining insured physicians' services, setting thresholds, setting fees payable for specific services, and the collection of moneys in excess of the prescribed amount are somewhat of a mystery to us. We say this because optometric OHIP-insured services are defined by the government and the fees for these services are set by the government. The existing legislation has allowed the general manager of OHIP to refer optometrists, when and as deemed appropriate, to the Optometric Review Committee. This committee has diligently reviewed patient records and has been successful in obtaining reimbursements to the government. Further, it has been established on the basis of an appeal to the Health Services Appeal Board, and is accepted in optometric cases, that in the absence of the required notation of information on a patient record, a service will be deemed not to have been provided. In the case of OHIP services, this would be a matter of automatic repayment.

Since the signing of the independent health practitioners social contract in 1993, optometric annual service billings to OHIP have been frozen at their 1992 level less 4.2%. As optometry is a young profession, with half of our members having graduated in the past decade, optometric practices are growing, and as the profession continues to grow in public trust and acceptance, our annual billings to OHIP have continued to grow. In year one of the social contract, our members had their monthly remittances reduced each month by an average of 7.5%, in year 2 by 9.28%, and in year 3 by 11%, which we have been recently advised will not be enough, so the average holdback for the year may well rise to 14%.

We have no problem, then, supporting amendments to the Health Insurance Act if we are correct in interpreting their intent and effect, which is to allow the Medical Review Committee to enforce reimbursement for the inappropriate billing of medical services and to allow OHIP to enforce repayment of moneys over the cap on medical services. This is no more than the situation that optometrists and other independent health practitioners live with now. In fact, under our social contract we asked for the establishment of a tripartite committee—college, OAO and OHIP—to review the criteria by which referrals were made to the ORC to see if these criteria needed strengthening. This committee never needed to function because the ministry had no problems with optometric referrals to ORC.

Dr Kniaziew: Schedule I, the Physician Services Delivery Management Act, will allow, we understand, the minister to proceed with initiatives which may not be consistent with his obligation under previously executed agreements with the OMA, including the 1991 framework

agreement and the 1991 interim agreement on economic arrangements, and will remove all risk of legal action for doing so. Specific items that have been reported as ending are the government's subsidization of Canadian Medical Protective Association liability insurance premiums and the joint management committee of the Ministry of Health and the OMA.

Again, we find ourselves in some agreement with the outcome of this action but we disagree with the method, which we understand empowers the cabinet to tear up the previous agreements made with the OMA.

Physicians were given a unique concession, at a not insignificant cost, never afforded to other health service providers when the government began to contribute to their liability insurance premiums. The amount of this contribution to physicians' liability insurance premiums equals approximately 20% of the total OHIP fee-for-service dollars budgeted for the services of chiropractors, dentists, physiotherapists, podiatrists and optometrists combined.

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In a similar manner, we do not believe the establishment of the joint management committee was a good move. Why should one provider group, albeit a very significant and essential one, be recognized in this fashion? Since the establishment of this committee, it has been our unfortunate experience that issues that affect all service providers or even just some providers were delayed while separate consultations took place with the OMA. If the OMA did not wish to discuss these issues, there was no opportunity for anyone to do so. This is not in keeping with the spirit or intent of the Registered Health Professions Act when it was passed in 1991. At that time, all three political parties hailed this legislation as establishing a new era in health care in Ontario, one that would move away from a medical model of health care delivery and recognize the contributions and expertise of other health care providers.

Significant issues in health care delivery, with significant cost implications, including the full integration of non-medical providers into the health care system, exist beyond the boundaries of hospital and physician budgets. A few examples that come to mind are the development of nurse practitioners, the acceptance of direct optometric referrals by physicians, the extension of hospital privileges to chiropractors and optometrists, and the restriction of physicians from filling health care functions for which they have no specific training, such as refracting physicians examining eyes.

Schedule G changes the basis of the Ontario drug benefit program by introducing user fee payments into the program. We are told that this program has user contributions in other provinces and that to this point Ontario has been unique in providing a feeless drug program to seniors and welfare clients. User fees are not new to the delivery of health care services in Ontario, so we express no concern on that basis alone. We do wish to express our concern, however, with the fee structure that is being proposed. We are not economists and we have no knowledge of how this fee structure was arrived at. We therefore urge caution and would like to see some further public consultation with the affected groups. This would

certainly help to provide reassurance that the government intends to protect the health care needs of the vulnerable in Ontario.

Before concluding, we would like to make one suggestion that might be applied to all aspects of this legislation, or at least to the ones which override existing agreements and affect rights of appeal and limit the powers of hospital boards, and that is the introduction of a time limitation clause. If such widespread powers are necessary to deal effectively with a range of health care issues—and we have expressed our concerns about some of them and our support for others—then some haste must be made to deal with them and then move on. Unrestricted powers are not democratic and should be challenged.

A lawyer writing on the op-ed page of the *Globe and Mail* noted the other day that even if the government had invoked the “notwithstanding” clause in the constitutional Charter of Rights, it would have suspended rights for only five years. So again we urge you to include an amendment to place a time limitation on this legislation.

In conclusion, members of the Ontario Association of Optometrists and our board of directors thank you for this opportunity to appear before you today. Health care is important to all citizens of Ontario, and preserving a system that can continue to meet the needs of Ontarians must be our collective goal. Prudent fiscal management of our existing resources is essential, and we sympathize with the task of the Minister of Health. From our experience, we know that healthy eyes and vision are positively related to our ability to meet demands in both educational and occupational environments. Early intervention and treatment can effect success in these environments. Furthermore, the research evidence suggests that groups already disadvantaged are more at risk for debilitating eye and visual problems and therefore less likely to obtain care.

Thank you.

Mr Crozier: I should tell the committee at the outset that the fact that Dr Kniaziew and I come from Leamington and that he is an outstanding athlete and I am a couch potato will in no way influence the questioning.

Doctor, welcome today. I want to start out by just pointing out, and I think you touched on it in areas of your presentation, that with regard to health care I don't think we should be under any illusion. This bill that's before us is a finance bill. It was presented by the Minister of Finance. It's called an Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring—which of course health care is part of—Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda. So I think the name of the bill alone tells us the objective of the bill, and that's to save money. So anything that we propose to the government should go to that end.

I don't disagree that we have to limit our spending, we have to reduce our deficit and work on our debt. When you mention consultation, or the lack of it, and your concern for your manpower review process, could you elaborate for the committee as to whether this manpower review process would have, as part of its objective, savings?

Dr Acs: Yes, it absolutely would have. When you're looking at eye and vision care in Ontario, you have to look at a little bit more than just the optometric profession. There are other providers involved in the system, so the picture becomes much broader. Unless you look at ophthalmologists and unless you look at opticians, and also, to a great degree more and more, look at refracting physicians, you don't look at the big picture. You cannot look at optometry alone. So it becomes a very complicated process.

But then when you start looking at optometry and the other professions, you start looking at things like geographic distribution of the various people who are involved in eye and vision care, the demographics, the primary versus secondary versus tertiary care that is delivered, and the level of training and the cost of the training of the various provider groups, it actually becomes very clear fairly quickly that given the previous factors—geographic distribution, cost of training, the profession itself—the most cost-effective and efficient providers of primary eye and vision care in this province are optometrists, which is where the cost comes in.

Ms Lankin: I might give you an opportunity to continue on Mr Crozier's question. I remember well during the final days of RHPA the debates around scope of practice in optometry and ophthalmology and opticians. Boy, oh, boy, it was a real immersion in the world of eye care for me as the Minister of Health at the time. I think it was important to leave room for a growing scope of practice as some of these issues around refracting physicians and others got sorted out and obviously still need to be sorted out.

Dr Acs: The more things change....

Ms Lankin: I'd actually like you to continue on your answer, because I'm interested in the issue of practitioner distribution—I use “practitioner” because I'm talking medical doctor and other health practitioners—in the relationship particularly in your field of expertise, what the restriction on billing numbers and restriction on some of those services might mean for your profession, and whether or not we've got the right tools to deal with that.

Dr Acs: Optometry is unique in the three O's, if you want to talk about eye and vision care, and that is that we are very well, evenly and widely distributed throughout the province. The profession of optometry thrives in small communities, so that there isn't a community of under 5,000 in Ontario that doesn't have the services of an optometrist provided to them. Even the northern communities will have optometrists flying in to various isolated hamlets to do eye and vision care. So the distribution of optometry has intrinsically evolved historically to be very good, excellent, in terms of primary contact. If we are the primary eye and vision care providers, and we do provide 70% of the primary eye and vision care, we are poised and properly distributed to be doing that.

So the whole question of the restriction of billing numbers and where you can practise, when that first came up under physicians under the social contract, was a wake-up call to us to say, if we are an OHIP—insured service and we have billing numbers and if it's happening to one group, then let's take a look at our group and make sure that 20 years down the road, as our profession

is growing and being used by the public, we don't have an oversupply in one area and an undersupply in another, so our members don't look back on us and say, "Why didn't you see this 20 years ago and do something about it?" which is why that clause was put in there and said we all have to sit down, we all have to work together.

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There are solutions to be found and some tough decisions have to be made in terms of whether it is appropriate to train a physician for so many years of medical school and then to have that physician provide the services of a refracting physician where all they're doing is a refraction and they're not really doing primary eye care. Is it appropriate to be doing that and to allow the system to be paying for it?

Mr Bob Wood: I have a couple of questions. You refer to concerns about medical records. You may be aware that the privacy commissioner has expressed certain concerns to the Legislature about the legislation as drafted. If his concerns were met, would you then be satisfied with that respect?

Dr Acs: Honestly, I don't know what those concerns were. If they would be available, I would think so, yes.

Mr Bob Wood: The second issue I want to address with you—and you made reference to what your profession has done about this—you may be aware that the physicians have a plan that they think is going to fully address the question of underserved areas. Do you think that plan is going to work and do you have suggestions for improving that plan?

Dr Acs: Boy, that's a tough one. Not having seen the plan, it's very difficult to start guessing ahead whether I think the plan would work. I can go back to what I know about optometry, and we've been very lucky and we haven't had to deal with this in the sense that we don't have overserved or underserved areas. But I know, human nature being what it is, individual practitioners who work individually like I do in a private office have a certain mindset and it's very difficult to move in certain directions unless they intuitively believe that that's what they want to do and that's where they're going to thrive and that's where they want to go.

I can imagine any kind of plan to redistribute things quickly, or even fairly slowly, would be very difficult and fraught with a lot of difficulties. You almost have to back up to year 1 med school if you want to make changes in those kinds of patterns of where people want to go and what they want to do.

Mr Bob Wood: You have a system that seems to have worked. What advice would you give the physicians in developing their plan? What principles would you apply to this?

Dr Acs: I think our system has worked because, as optometrists, we have always felt ourselves to be underdogs. We have always felt ourselves to be the lower guys on the totem pole and we're always chasing the big guys up there. So, in a way, when you're second, you try harder and you somehow make it work better because you have no choice. This is imposed on you, this is how you're going to do it.

Dr Kniaziew: Just a comment. Communication—working as a team would help.

Mr Bob Wood: Your answer in essence to them would be communication and focus?

Dr Kniaziew: Correct.

Mr Bob Wood: I think we've actually got them focused on the problem. I'm confident, I might say, that this plan is going to work. I don't think there's going to be any necessity for doing anything further. The minister has made that quite clear. If this plan works, he has no interest in getting into the issue at all.

The Chair: Thank you, doctors. We appreciate your presentation this morning.

LONDON SOCIAL PLANNING COUNCIL

The Chair: Our last group for the morning is the London Social Planning Council, represented by Alice Kendall, the vice-president, and Gary Davies, the president. Good morning and welcome to our committee.

Mr Gary Davies: Thank you very much. I'm Gary Davies, president of the London Social Planning Council, and Alice Kendall is our vice-president. We were both elected to these positions last October at our annual meeting and so, for us, we are coming here as volunteers today. However, I think in the course of our presentation you'll discover that we both have other hats we wear and we'll be drawing on our experience in other places to bring to bear in our presentation today, which is in two parts actually.

The first part is some detailed comments on Bill 26 itself, which Alice will present, and then later I have some concluding comments about the bill and I would like to draw on a particular area of practice in health as it relates to planning because that's the interest of our planning council. Perhaps we can have some discussions after that. So, Alice.

Ms Alice Kendall: On behalf of the London Social Planning Council, I'd like to thank the committee for the opportunity to put forth our views and concerns regarding Bill 26. It caused us grave concern when the provincial government attempted to pass this piece of legislation with no public consultation. This action indicated blatant disregard for the democratic process valued by the citizens of this province. Our concerns have not been eased by the knowledge that the standing committee's report to the Legislature on January 29 has been allocated a time slot of 10 minutes. This is obviously an inadequate period of time to report on all the concerns expressed by groups and individuals across this province. We hope this does not indicate that our government is extending lip-service only to the people of this province.

Actions of the provincial government over the past few months have been devastating many individuals and families in this province. Dramatic cuts to social assistance benefits, regulatory changes that completely cut people off the financial assistance of last resort and the elimination of many support agencies have resulted in people in this province without the ability to provide basic necessities such as food and shelter. This has entrenched them deeper into the cycle of poverty.

We are aware that living in poverty causes increased health problems. Money saved by forcing people deeper into poverty will be quickly spent by the additional

burden on the health care system, unless, of course, legislation is passed which makes health care less accessible to those who require it more, legislation such as that which incorporates user fees, extra billing and reduced health care coverage.

Bill 26 should be rejected by all Ontarians who value a quality health care system accessible to all, no matter what their economic status. Reduced health care coverage, user fees, deregulation of drug prices and extra billing reduce access for middle-income families; it eliminates access to many low-income families. Thousands of families will be forced to choose between health care services or required medication and feeding their families. What kind of choice is this?

One such family residing in London is already desperately affected by the cuts to social assistance benefits. The provincial government had promised that disabled people receiving social assistance would not be affected by the 21.6% cuts. What they mean is that disabled adults receiving family benefits allowance will not experience the cuts; disabled children will.

This family includes a chronically ill two-year-old little girl who is dependent upon a respirator. She is tube fed and requires 24-hour day care. Her parents are struggling to keep her in their home with her two siblings. The love the parents have for their child can be easily measured by the sacrifices they have made to ensure their daughter is in the best possible environment with the best possible caregivers, her mother and father. The care of this child requires the parents to be on duty 16 hours a day and on call for the other eight hours, except on Sundays when they are on duty for 24 hours. These parents both have a background in nursing. They are trained to deal with her daily needs and are well aware of her medical needs.

The expense to this family of keeping their daughter at home with her family is enormous. The surgical supplies and diapers alone amount to hundreds of dollars per month. Her parents cannot take paid employment outside of the home; they both work full-time within the home.

These parents do not begrudge the money, time or energy required to care for their child. She is, after all, their little girl. Their stress is caused by the increasing prospect that they will no longer be able to maintain her health at home as they will not be able to afford to. To hospitalize this child would devastate the family, including this child and, incidentally, will cost the health care system thousands of dollars a day.

In a second family, a single mother of a child with environmental allergies survives on social assistance. This child too was hit by the cuts to the social benefits. His mother hopes that she can continue to live in the home she has customized to her child's specific medical needs. He cannot go out to play with neighbourhood children or attend nursery school. Contact with people outside of his controlled environment will make him ill and he will be hospitalized.

The mother secured accommodation with a fully fenced yard. This way her son can at least play outside without the danger of contact with others. She cannot secure paid employment outside of the home. Her child cannot attend a child care centre and, furthermore, an

employer will not hire a person who must take her child to the hospital on a regular basis to receive drug therapy.

A third family, a London couple with three children, are now receiving unemployment insurance and a top-up from social assistance. This time last year they were both employed outside of the home. This time last year they lived in a comfortable three-bedroom home, had two cars, benefit packages from work, and enjoyed a two-week family camping trip once a year. Now this family lives in a cramped two-bedroom apartment, has one car which sits in the parking lot as it requires expensive repairs and cannot afford a family trip to McDonald's. In fact, since October 1995 they've had to access the food bank by the middle of every month when their money runs out.

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What will Bill 26 mean to these and all other families surviving on limited incomes? It will mean limited access to quality medical services and often no means of providing necessary medication. It will mean the choice between providing for their children's medical needs and providing other basic necessities such as food and shelter. It will mean that fiscal and budgetary reasons alone, dictated by government, will determine what medical services these children receive rather than a medically qualified health care professional. It will mean an American-style health care system where the experienced health care professionals are not available to treat their children's fragile medical conditions.

For cabinet to have the ability to make regulations which would allow fees for such things as accommodation and meals while in hospital, charges for necessary nursing services, for laboratory tests or emergency room visits, is an obvious and obscene barrier to health care for low-income citizens. We cannot allow a health care system to be created where a parent must look in his or her wallet before taking a child to an emergency room.

Charging a fee for prescription drugs to the people least able to pay—seniors and those receiving social assistance—simply means that they will not be able to obtain necessary medication and will become sicker. The families I have outlined today cannot afford to pay for medication. However, these children cannot afford to go without it. A family who cannot afford food in the middle of the month will not have spare money put aside for health care services or medications.

The ability to allow independent health facilities to charge fees over and above what is covered by OHIP is extra billing. It creates a system where the most experienced health care professionals are inaccessible to the low-income community.

Only qualified, expert medical professionals have the ability to determine what medical services are necessary. Giving cabinet the power to decide what services are to be insured by OHIP is incomprehensible. This will allow budgets to determine which child will or will not be treated.

Bill 26 eliminates quality, accessible and affordable health care for many Ontarians. It creates stress and turmoil for families who are attempting to raise healthy children. It creates a situation where parents will have to decide between food and medical services. Then, to add insult to devastating injury, it gives the Minister of

Health the power to collect and have use of personal medical information. It takes the right to privacy from these and every other Ontario family.

As articulated by a co-worker, "Deny food to one child, you call it child abuse; deny food to 40,000, you call it deficit reduction." Change the word "food" to "health care" and you express the same sentiment.

Bill 26, if passed, will be responsible for the abuse of thousands of children in this province. We hear this government justify its actions because of its concern for our future children. Let us not forget the children of today. Do they not deserve access to health care services where a qualified medical professional determines that it is required?

Throughout the election campaign this provincial government promised no cuts to health care; you promised that user fees would not be introduced. We demand that this government demonstrates some care and compassion for the people of this province. Withdraw Bill 26 in its entirety.

Mr Davies: Thank you, Alice. I have some general follow-up comments to what she has said and then I want to go on and discuss a particular target population within the health care area.

First of all, I think it's important that a bill with such an impact be reviewed, and certainly it's good that this meeting and others across the province are occurring during the course of the month. There has been some concern expressed by some of our members about the transfer of some responsibility to the voluntary sector and in particular to the United Way, for example, and to the churches. I mentioned at the beginning that we speak with different hats and I've had quite a bit of experience with both those areas. They have no power, other than moral, to raise funds, so to transfer some of that responsibility is perhaps regressive.

However, having said all that, we firmly support the need for the province to live within its means and for agencies to live within their means. We try to live within our means as well, as agencies or as the social planning council, although they are certainly limited.

I don't know if it's been mentioned by others, but we can't forget the role of the federal government, which has been dismantling the Canada assistance plan. That has a spillover effect on the funding of many of the social and health programs in Canada. That has been one of the most, if not the most, significant piece of funding and social services legislation in this country in the last 30 years.

Some people earlier today talked about supporting the individual privacy of medical records, and we support the government in its intent, or promise at least, to change some of the provisions of the bill to make sure that happens.

Hospital restructuring is going ahead very quickly in London, as you know, through LACTHRC and the Victoria and University hospitals merger. Both of those processes have involved a lot of local participation, and it's very important to have local ownership as part of processes like that.

With respect to the operation of social planning councils generally in Ontario, and there are about 30 of

us, two thirds depend for funding to a greater or less extent, mostly fairly significantly, on municipalities, be they regional or local governments or city governments. Certainly there will be some reduction in municipal funding and that is going to have some impact on the role of social planning councils.

Switching to the different letterhead you're looking at, another role I play in London is as the executive director of the social planning council. I thought I would take this opportunity to use the planning for services to the head-injured population as an example of where we're at with one particular target population as it relates to health services generally.

Some current facts: Every year probably around 12,000 new people are admitted to hospital or at least seen in medical facilities with a brain injury. Traffic accidents cause about 50% of these; younger males are the largest group affected. Probably a couple of thousand, 2,500 or so, people annually are left with significant lifelong problems in a number of different areas. You have a brochure from our organization that describes some of the difficulties people face. It's important to remember that brain cells do not heal. Doctors were in the room before. I'm sure they would back us up on that. Bicycle accidents have been a leading cause of acquired brain injury for youngsters.

Starting in the mid-1970s and through some of the efforts of the district health council here in London, a number of different studies have been done on the systems for services to the brain-injured. I'll use brain-injured and head-injured almost interchangeably here; it doesn't make a whole lot of difference.

It's been very hard to estimate the size of the population and some more work is needed here. Perhaps the most recent study, A Continuum of Opportunity for People in Ontario with Acquired Brain Injury, was completed in December 1994 by a very impartial, non-partisan group representing a number of agencies, government people from all across the province, involved agencies and individuals, academia, institutions and so on, and was submitted to the Ministry of Health in February 1995. To date, as far as I know, there has not been any action taken on this very excellent planning model. I will say a bit more about it later on.

One of the issues discussed in this report, however, was the fact that many people are being treated in the United States. Our movement in Ontario, the Head Injury Association movement, was very pleased to hear the minister's announcement in November, I believe, that about 75 people would be repatriated from the United States, not only to save some money—and the current cost down there is around \$21 million—but also to ensure that they receive treatment at or as close to home as possible. In previous careers I have held, that has been a principle I strongly believed in, that if you have to receive treatment of any kind, you receive it in or as close to home as possible. We appreciate that, and certainly that was one of the issues discussed in that report.

1150

Another project which has been led by the Ontario Brain Injury Association is called CISL, the Caregiver

Information Support Link. In the last few years it has been generating a lot of useful information about the nature and extent of the difficulties that people with brain injuries face, and also their families and their colleagues and co-workers and so on. As I say in my written remarks, this project is still in its infancy, and the information coming out will more usefully inform the planning process for this particular target population.

When the Minister of Health was here—it might have been in this hotel—in November 1995, he told the Ontario Public Health Association that “every effort”—those words are in quotes in the media—would be made to directing some of the savings from the merger of hospitals towards, again in quotes, “beefing up” community-based services as the hospitals downsize.

The comprehensive system laid out in this report gives an important role for the head injury associations in Ontario in both community support and in prevention. Logic would suggest that as a legitimate part of the service system, some of those funds saved from hospital changes might be diverted to the head injury associations or at least to some prevention and community support work.

I won't dwell at great length upon the insurance industry. We have made a submission, I believe, to the government about the OMEGA proposal; that's only car insurance. Another concern we have with respect to insurance is that very often the establishment of the cause of a brain injury is seen to be more important than the recognition of the fact that a person has certain needs that need to be met. I suggest it would be more useful if the primary effort could be devoted to offering treatment without delay and leave sorting out the responsibility for payment till later on. I know governments have some control over the insurance industry, but there needs to be some dialogue to sort out some of these difficulties. It isn't just for the patients, but their families often are facing some hardships as well.

I'm glad to see that Dianne Cunningham has come back into the room, because with my next point I certainly have to accord her some recognition for the role she played in bringing the bicycle helmet legislation, as we have called it, into force in the province. I have to confess, though, that we've got some disappointment that it did not extend to people over the age of 18, in spite of overwhelming evidence that mandatory use greatly increases compliance. Some of our medical colleagues in London have said that accident reduction could be at least 85% with helmet use. It has been mentioned that adults have some responsibility for looking out for themselves. I think that has to be weighed against the lifelong costs of treating a head-injured person, which may well exceed \$1 million to \$2 million currently.

Last October, a London Free Press editorial implied that “Cuts Without a Map,” and that was the heading of the editorial, were dangerous. Without service plans, services could go anywhere. There is a little story in Alice in Wonderland where somebody says, “Where are you going?” The response is, “Well, anywhere.” “Then I guess you'll get there.” If you really don't have a plan, you won't know where you're going. There is a good plan in the Continuum report, and the editorial went on

to say, “The Conservatives should not be so quick to throw away well-charted maps to greater savings.” I think this applies with respect to this report. We'd like to have some response and dialogue on that, not just as a local head injury association but provincially speaking.

Our association covers a five-county area, Elgin, Oxford, Middlesex, Huron and Perth. There are approximately 680,000 people living in that area. We would have to consider them all members of our target population. Some of the estimating tools we use to estimate the target population have to be used with great caution, but probably there are between 1,000 and 3,000 people living in that area with the effects of head injury, and don't forget it spills over into families so there are effects on other people as well, and perhaps as many as 1,500 new people a year will receive a head injury in this area. The needs of these people and their families and friends and colleagues and coworkers and so on, considering the lifelong impact associated with brain injury, merit careful consideration using the planning tools we have, such as this report.

Those represent my remarks. Thank you for having us come this morning.

Mrs Boyd: Thank you both very much. One of the issues for us is trying to put into context the individual problems of particular associations that deal with specific injuries and also individuals trying to cope with the implications of Bill 26. We need to get a sense of what you as a social planning council think the dangers are of this kind of omnibus legislation and the lack of consultation in terms of an orderly planning process for health care and the determinants of health in our community.

Ms Kendall: I think this government hasn't recognized the impact at the ground level, the impact on individual lives this bill will have. We talk about deficit reduction, but at what cost to our communities, at what cost to our children, to families in these communities? We can talk about the future, but we have communities that exist today, and there has to be a balance.

Mrs Ecker: Your joint presentation illustrates very well the very difficult but, I believe, very necessary balance between a government trying to live within its means and at the same time provide services for those who need them.

The point about being able to repatriate those with brain injuries: We've been able to reinvest \$12 million to bring back about 76 patients so far to Ontario, where we believe they will be cared for better. We've been able to do that because of the kind of restructuring we're doing in the system, so we can find savings in one area to bring forward in another.

One of the things I have heard from the communities within the Community and Social Services area is that one of the difficulties with getting some of that money to the front-line services is that there is a multitude of agencies. One suggestion that has been brought forward from individual groups in my area is that we have more direct funding to actual families, more direct payment to the individual or the family with the special needs rather than filtering it through an association or an agency. Have you got any comments about that suggestion that was made to us?

Ms Kendall: When we're talking about getting these resources directly to families, by the same token, they've cut benefits 21.6% and then said that to provide medication to your child, you have to pay a user fee. If somebody's child has an ear infection on the 20th of the month, the chances of them having any money to get the antibiotics to clear up that ear infection are just not going to be there. These families are already using the food banks and don't have access even to what you would consider a small user fee. It's a large user fee when you don't have it.

Mrs Ecker: But 140,000 more people have got a drug benefit plan now under the system.

Mrs Pupatello: Mrs Ecker is describing a health voucher on the head of individuals, much like the child care voucher. While in concept and theory that's wonderful, the reality is that even with the child care voucher, when you cut the value in half, you can't access good quality at the appropriate level. Whether it's health care you're now using as a voucher or child care, it's still not available at a quality level. That's the danger of that kind of approach, and I know your organization has looked into the critical area of child care.

With all the things you've mentioned about the reallocation going on in the London area, the minister is on record in the House as saying that savings from hospital restructuring will not go back to that community, so I'm just hoping you're not holding your breath for that. That is what has been said. We have tried to pinpoint the minister on several occasions and he simply has said no. That's on record. For any government members today to suggest that they're making a commitment to any local community to reinvest those savings is simply not on side with their own minister.

Mr Davies: I just have a comment about flowing funds to individuals versus flowing funds to agencies. From our perspective in London—and I can't speak on behalf of the whole movement in Ontario—we would regard community support and prevention as probably the two major flagship programs we operate, and in the area of community support the intent is to have people come together, not to remain in their homes. Our job is to facilitate the coming together. With respect to prevention, I mentioned that it's a job that has to be done with respect to almost three quarters of a million people whom we see, and it can't be done on a one-by-one basis either.

The Chair: Thank you very much. We appreciate your presentation and your interest in our process. We're recessed until 1 o'clock.

The committee recessed from 1201 to 1302.

LONDON AND DISTRICT LABOUR COUNCIL

The Chair: Our first presenter this afternoon, to represent the London and District Labour Council, is president Rick Witherspoon and Jim O'Leary. Welcome, gentlemen. You have a half-hour.

Mr Rick Witherspoon: First of all, Mr Chairman, I'm Rick Witherspoon, president of the London and District Labour Council. We represent something in excess of 20,000 members in the city of London and surrounding areas. As you will be aware, we made a presentation last

week with regard to the general portion of the bill, raised our concerns with a number of specific areas and, of course, raised our concerns with the process that is taking place with regard to the hearings on Bill 26.

The reality is, our position at that point in time has not changed; we still think that the hearings should be expanded to allow those groups that have not been given the opportunity to make presentations, that they will be given that opportunity. Again, the reality is that the hearings are taking place across the province because of the actions that were taken in the Legislature to force these hearings to take place, and the unfortunate aspect of that is that it is still the government's intention to go back into the House with one more day of the Legislature and ram this bill through. The implications of it in general form, certainly in the area of health care, are going to dramatically affect everybody in the province of Ontario, and with the sweeping changes that the bill imposes, I think it is imperative that the current government take the time to listen to your constituents across the province and ensure that they understand the issues, and if in fact there are going to be amendments to the bill, that they understand those clearly.

I find it extremely difficult to understand that this government that has clearly said it is going to put amendments in place is still not prepared to let people know what those amendments are so that if we have issue with amendments, we could deal with those. The reality is, as I've said before, this is going back into the Legislature for one day, so nobody is going to have any opportunity to deal with the bill as amended before it is passed through the House.

The follow-up portion of the presentation today is going to be presented by Brother O'Leary, so I'll give him the opportunity to take over at this time.

Mr Jim O'Leary: I'm a medical laboratory technologist working at Victoria/University Hospital in London.

On behalf of the London and District Labour Council I want to express our utter disbelief that in this day and age a government would attempt to pass legislation that would take away the rights of its citizens and move us back to an age of inequality.

Not since civil rights were suspended with the imposition of the War Measures Act in 1970 in the fight against terrorists in Quebec has any piece of legislation attempted to undermine the democratic rights of its citizens. With the presentation of Bill 26 in the Legislature, Mike Harris has declared martial law on the health care system in the province of Ontario.

Such an approach to health care, however, should not come as a surprise. During the 1960s, when the Canada Health Act, which set up universal health care in Canada, was debated in the House of Commons, the Conservative Party of the day argued against it. Their preference was to let private insurance companies run our health care system for profit. Nothing seems to have changed in 30 years.

Bill 26 would create the Health Services Restructuring Commission. The legislation does not specify the exact powers of the commission, but provides that the commission can be assigned duties by regulation under terms and conditions determined by cabinet.

Does it mean that the communities we live in will have little or no say on the delivery of health care? Does it mean work done by district health councils will be substituted by bureaucratic decisions made in Toronto?

In fact, with Bill 26, the Minister of Health can make any direction related to a hospital that he wants as long as he considers it to be in the public interest to do so. According to the bill, the public interest is defined as what is of interest to the Minister of Health.

We find it difficult to understand why, if this government is acting in our best interests, the cabinet have provided itself with immunization against any liability for damages arising in the course of carrying out its powers so long as they act in good faith. What has happened to one of the basic principles of democracy: allowing citizens access to an independent judicial system?

The bill would eliminate the requirement now contained in section 3 of the Independent Health Facilities Act that preference to operate independent health facilities be given to non-profit Canadian operators.

Under Bill 26, the minister can direct that a request for proposals be limited to one or more specified persons. This raises the real possibility that for-profit US health care providers will be licensed to provide our health care needs in the future. There will be no obligation to notify those who submit unsuccessful proposals or to give reasons for these decisions, with no right to appeal.

Without a tendering process, the door is open for the entrance of the American two-tier health care system, a system that costs far more than ours and leaves millions of its citizens without health care.

In tandem with the massive cuts to hospital services, the new legislation will allow the Minister of Health to handpick corporations or individuals to fill gaps created in the system with private clinics or organizations intent on profiting from the sick and the elderly. As I speak today, American corporations are poised to move in and mine this untapped resource. Do you think this is what the people of this province wanted when you were elected? I think not.

In the case of medical laboratory services, profit-making has cost the system dearly. It has been shown that the private sector medical laboratories are 34% more costly than their hospital counterparts. In fact, recent research proves that if hospital laboratories were allowed to compete fairly with private labs, the taxpayers of Ontario would save \$106 million annually. Why would this government ignore this opportunity? Putting dollars into the pockets of corporate shareholders has priority over using the taxpayers' dollars to fund health care responsibly.

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The present act prohibits any person from communicating confidential information relating to a patient or former patient of a health facility, with narrow exceptions. The bill provides that, notwithstanding this protection, and for any purpose prescribed by cabinet regulation, the minister can collect, use or disclose personal information, and the minister can enter into agreements to collect, use or disclose personal information.

We are now living in an age of computer databases where people are becoming more concerned about

personal privacy. What does this government want to do with this information? Will private insurance companies have access to this information? Will it allow them to determine who is insurable? Will this government sell this information to private companies to screen job applicants, or use it themselves for the same purpose? The Harris government clearly feels that economic considerations should override the rights of citizens to have a person's personal medical history held in confidence.

Proposed changes to the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act will introduce copayments and deductibles for seniors and social assistance recipients.

All recipients of ODB benefits will now pay a minimum \$2 charge per prescription. In addition, where individual income exceeds \$16,000 or a family income exceeds \$24,000, a \$100 per person deductible per year will be instituted.

It also deregulates drug prices. Ontario will become the only province in Canada that does not regulate drug prices. Will this mean that you will go to your pharmacist and haggle over the price you pay for your drugs, as you do now with grocers over the price of your tuna? Where is it going to stop?

In 1970, the War Measures Act allowed the federal government to throw anyone in jail without a reason and without legal recourse. Bill 26 amounts to the same approach: martial law. Putting absolute power in the hands of cabinet sidesteps debate in the Legislature. It hides government actions from scrutiny and undermines the basic democratic rights of every citizen to be informed of not only what the government is doing but why.

A government which believes it should merge or close health care facilities, dictate to or overrule community boards, collect and use private medical information, has assumed dictatorial powers. In the interests of the citizens of Ontario, I hope everyone in this community will exert pressure on their MPPs to defeat this omnibus bill.

Ms Lankin: Thank you for your presentation. I have questions in a couple of areas that you've raised and one area that you didn't directly touch on in your brief. First of all, Jim, you talked about the role of the Health Services Restructuring Commission and you're quite right, there are no terms of reference, there's no mandate, there are no powers or limits on the powers set out, and there's no explicit connection to the work of local planning studies, often being led by district health councils around the province.

We've been urging the government to consider explicit amendments in this area that leaves us not so wide open to just the minister's decision-making, and actually links the work of this commission to implementing local planning reports and the consensus arrived at at a local level. I realize you'd like to see the whole bill defeated. Many of us think this needs a lot more time, and there are pieces of it that we could support and other pieces we couldn't. But if it proceeds, do you think that would be a useful amendment and do you have any comments on what should be contained in it?

Mr O'Leary: Absolutely. I think community boards and district health councils across this province have done

an enormous amount of work over the past number of years. Restructuring has been happening in this province very quickly in the last two years in Sudbury, in Ottawa, in Toronto, in London and other places as well.

What this bill does, it could eliminate all this useful work that's been done with all the community input that people have to put into their hospitals. What we're afraid of with this bill is that the government can come along and disregard everything that's been done, all the work that's been done, and just impose its will for economic reasons only and not with the interests of the community in mind.

Ms Lankin: In addition to that concern, one of the other concerns I have is that any one partner in the community who may be dissatisfied with the end result of the community consensus, if they happen to be a powerful voice, has a pipeline to the minister and has the ability to sway the minister in terms of that decision. I think we've already seen that happen in a couple of communities. So that's an area we'll be working on in terms of amendments.

I have another question I'd like to ask you. You didn't explicitly talk about schedule Q, and that's before the other committee, and that's to deal with powers in fettering arbitrators' decisions in public sector interest arbitration. I raise it because in fact your employer was here this morning, and representatives from the board made a presentation. They talked about not only supporting the fettering of arbitrators' decision-making powers but they wanted it to be even stronger.

I wanted to raise this with you because I think it's important that people have a chance and government members understand why the arbitration system is there in the first place and the fact that this is a system attempting to replicate free collective bargaining. By imposing an ability to pay, I understand the hospital's frustration: It's like the government is a ghost at the bargaining table; it determines the amount of money and then the hospital is sort of stuck there.

But by entering into this world of ability to pay, the inevitable result I would see is that public sector workers are going to be asked to subsidize the cost of delivery of public services. I would say to you directly, as a laboratory technologist going back over the years in interest arbitration, and I'm thinking of the arbitrator Verity award, if it hadn't been for that process, of being able to take a fair look at things, the issue of equitable wages between the nursing profession and laboratory technologists could never have been dealt with. Could you share with us some comments on that section and perhaps provide the government members with some alternative views to what we heard this morning?

Mr O'Leary: I was quite surprised this morning. I heard Mr Dagnone, the presentation they gave from the hospital. They wanted to have a one-board arbitration, appointed by the government, that would sit permanently to determine these matters. That scares me. I don't think that would work.

What we have now is a system where arbitrators are agreed upon by the employer and by the union. I think we get a much fairer result because of that. That happened with Mr Verity's award, where they brought the wages that people in the hospitals were making up to the

level that the community was making, that people doing similar jobs outside of the hospitals were making. At the time, they were grossly underpaid. At the present time, I think it's a more equitable solution. The changes that they've wanted, that the hospital even proposed this morning, surprised me, that they wanted to expand it even further than they did.

Ms Lankin: If you're in a collective bargaining situation and you know that the government has dictated the level of services the hospital must provide, so they must do a certain number of things with the money they're given, and the government also determines the amount of money the hospital gets, what are you going to be faced with across the table in terms of what the hospital is going to say to you and, inevitably, if you choose to go to arbitration, either party, to the arbitrator? What will it mean in terms of your ability to represent workers and to get salaries that are comparable to free collective bargaining situations where the right to strike exists?

Mr O'Leary: I think it destroys the whole arbitration process. It doesn't allow arbitration to take place the way it's supposed to at all; it wouldn't.

Mr Witherspoon: If I could, because I think your point is well taken, we did address this when we made the presentation last week. Of course the concern is that it defeats the collective bargaining process, particularly where the various criteria are put in place that are going to affect the arbitration process. Knowing full well that if you are using ability to pay as one of the criteria, the premise can be made, then, that we simply make sure that budgets don't allow for the funding to increase wages and in fact impose wage control in that fashion.

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Mr Clement: Thank you for your presentation. We heard earlier today from the hospital with which I believe you're associated, Victoria/University, about how they saw the restructuring of hospitals and they made an important point which I picked up on, which was they agreed that restructuring had to take place. They had some suggestions to us about how to balance the authority of the minister with the local area, and I want to assure you that if you read the Ministry of Health Act, the district health councils are still mentioned. They are still part of this legislation.

Read section 8.1 of the act, which has not been repealed, has not been altered, has not been changed by this legislation. The district health councils are still there. So if I tell you that, and if you could re-read the act, does that give you some comfort that the district health councils are still part of the process?

Mr Witherspoon: It doesn't give me any comfort because the reality is the legislation, in my estimation, supersedes what the health councils are going to do.

Mr Clement: Well, sir, I guess reasonable people are going to have to disagree, because if you read the act, section 8.1, which deals with—

Mr Witherspoon: I've read it.

Mr Clement: —district health councils, it is still there. We haven't repealed it. District health councils are there to analyse and advise and plan. They still have that responsibility under the legislation.

Mr Witherspoon: And the minister has the ultimate authority to overturn those decisions.

Mr Clement: That is the case now, sir. Can I just deal with another part of your brief then. You state that the minister under Bill 26 can enter into agreements to "collect, use or disclose personal information." Did you know that under the old legislation the minister could enter into agreements to collect, use or disclose personal information?

Mrs Caplan: You have to make him tell the truth. That is absolutely misrepresentation.

The Chair: Mrs Caplan, Mr Clement has the floor.

Mr Clement: Subsection 2(3) of the Health Insurance Act, "The minister may enter into agreements to collect, use or disclose personal information relating to eligibility." It's in the old act. So who is telling the truth here?

Mrs Caplan: Mr Chairman.

The Chair: Mrs Caplan, Mr Clement has the floor.

Mr Clement: Who is telling the truth here?

Mr Witherspoon: I think the reality of the bill, and I'm not sure what you're reading in the old act, but—

Mr Clement: Subsection 2(3).

Mr Witherspoon: All right. And what's before it and what's after it and what does it pertain to? You know, it's no different than a collective agreement. When you relate to one section, you have to relate to 10 other ones to determine what you're going to do with it.

Mr Clement: No, I read you the old section, sir—

Mr Witherspoon: This one clearly says that you have the right to do that.

Mr Witherspoon: You can identify one.

Interjection.

Mr Clement: I'm just trying to correct the record. With respect to Ontario drug benefits, you've raised some important considerations for there. If I told you that 50% of low-income seniors, according to our estimation—it's our estimation—would be paying \$32 per year or less for their drugs under our plan and that only 10% would be paying \$110 or more, would that give you at least some comfort that the great bulk of seniors are not affected by this legislation deleteriously?

Mr Witherspoon: I don't have any comfort with this act at all. I don't have any confidence that this government is going to continue to do what's been done in the past. Obviously with this bill, with Bill 26, the government is intent on stripping people of the rights and the privileges that they have now.

Mr Clement: If I put it to you this way then, because this is the intention of the government, to restructure the health care system to deliver the dollars where they are needed because in this community, as in other communities we've heard about, the real needs of the community, in community health, in palliative care, in long-term care, there are lots of areas that do need more resources, but we need to find the money from somewhere. You know it doesn't grow on trees, so we have to restructure the way we deliver health care.

Mr Witherspoon: I could give you an example of resources here. The Laurentian Group in Sudbury of Doctors Bonin have approached the government with a plan to save, as I said, \$106 million annually on laboratory services alone. That money could come back into the

system. They approached the present government with the plan to do this and it ignored them.

The plan called for hospitals to be able to bill at two thirds—not the full rate, at two thirds—the rate that private laboratories now bill the government for their testing, and this would be a windfall for this province. There would be over \$100 million that could come back into health care that could fund other areas that you're talking about and this government chose to ignore that.

Mr Clement: We're looking at all ways to fund. I do not make any apologies for the fact that we're looking at any way that we can deliver the services more efficiently. So I can assure you that that's the intention of this government.

But I guess my point is, we've got to restructure. We've got 9,700 empty hospital beds, by last count, in this province where we as taxpayers still pay for the heat, for the electricity, for the administration and then we've got other areas in our health care system that are crying for more resources. So don't you think we should at least give the minister the ability, even in a sunsetted and a time-limited fashion, to obtain some savings, make sure that we have a health care system that is efficient so that we can do the things that we have to do in the health care system and rechannel some of the money into the areas that need those increased resources?

Mr O'Leary: Let me ask you a question. Would you give someone the ability to have control over your life with no recourse to the courts, and this person would have absolute control over what happens to you? This is what this bill is trying to do.

Mr Clement: No, that's not true. Let me ask—

The Chair: Thank you very much, Mr Clement.

Mrs Caplan: Over the course of the last few days Mr Clement has been attempting to put forward a categorization of this bill which is absolutely incorrect. So I would like, if I could, to read a legal opinion into the record which I think will help to clarify for Mr Clement and the government that what they are doing is in fact not what Mr Clement says they are doing, and that your concerns are absolutely valid.

I'm just going to read it as follows:

"It has been stated"—by Mr Clement—"that section 21 of schedule H narrows the effect of section 29 of the Health Insurance Act. It might be so claimed because in section 29(2) of the Health Insurance Act it states that every insured person shall be deemed to have authorized a physician to provide the general manager with information respecting insured services for the purposes of the plan.

"In section 21 of schedule H, specific purposes are set out in subsections (a), (b), (c)." That's what you've been referring to, and he's nodding his head.

"However, such an interpretation would be in error because the reference to purposes of the plan in the Health Insurance Act 29(2) must be read in conjunction with section 10 of the Health Insurance Act which states that the purpose of OHIP is to provide for insurance against costs of insured services. Therefore, the actions of the act must be limited to those things which relate to the purpose of the plan, and only those, and therefore the information authorized must be for the purpose of

providing insurance against costs and is therefore, not"—and I stress "not"—"personal health information.

"Furthermore"—Mr Clement—"such interpretation would also be in error because section 21(1)(d) of schedule H allows the minister"—under your Bill 26—"to prescribe any other purposes. This therefore specifically and directly removes any limits on the information which may be collected. This would massively increase the purposes as stated in the Health Insurance Act presently in section 10."

That's what we've been saying to you. I know that Ms Lankin, also a former Minister of Health, will agree with this interpretation. You're absolutely wrong to suggest that those powers are already contained in this act. Bill 26 massively increases and enhances to the point where the Minister of Health has absolute control over every aspect of the delivery of health services and every right under this legislation to micromanage the system, to have access to patient records, for whatever purpose he would set out, and no one can sue him if they disagree with how he's used that information or disclosed it. And that's the truth. Now, withdraw. That's this law.

Interjections.

Mr Clement: I'll get my lawyer to call your lawyer.

Mrs Caplan: Well, you're a lawyer and you should know this. And to not do that is a clear misrepresentation of what is in this bill. You have to tell the truth here.

Mrs Papatello: I just want to say, for your information, Mr Clement is attempting to do this in all of the communities he visits in an attempt to trip up those presenting. So we're glad to see that you certainly are informed as presenters.

I wanted to simply make the point that you stressed in your presentation about drug coverage and health service and what's going to be considered covered etc and available to all, and who really pays what no longer will be listed. Because at the end of the day, from your perspective—and you're probably involved in contract negotiations—when services become delisted they now become part of a bargaining parcel that you must go after for the employees who are part of your union. At the end of the day, as is the case in Kentucky, where there's a perception of cheap labour in the States, the reality is that in a state like that the companies have difficulty maintaining their good workforce unless they have great packages they can offer, especially health service.

Because we are now Americanizing our Ontario health care system, Chrysler, Ford, GM—big business, I would submit, which this government assumes is on its side in this—will end up paying the price, because for them to remain competitive, they now will have to pay for those services that are not being covered for individuals. It will become part of the bargaining process and that package. I'd just like your comment on that.

1330

Mr Witherspoon: The point's well taken. Of course I think, as representatives of workers, what manages to get legislated away we're certainly going to attempt to try to maintain on behalf of our members through the collective bargaining process.

Mrs Papatello: And you compete and companies compete with themselves, within their sector as well. So if one offers, the other must offer and so on.

Mr Witherspoon: To a certain extent obviously. You've spoken about some of the major corporations, and I'd like to think that certainly the Big Three negotiations do have a spillover effect into other negotiations. If we're able to achieve those types of things on behalf of our members, certainly it sets a benchmark for other people to go after.

The unfortunate part we see within the whole process here is that we're now seeing a government that even though you do attempt to go to the bargaining table and put together a collective agreement on behalf of your members, the government wants to then have the power to overturn many of those decisions. So with the stroke of a pen, you can lose—

Mrs Papatello: Even if it is a private negotiation—

The Chair: Thank you, gentlemen. We appreciate your being here today and making a presentation to us.

I'd just like to remind the members of the committee, our purpose in all the communities we go to is to listen to the people and to bring forth their concerns. I don't believe it's productive for us to get into long arguments with one another. That does not allow the people who come here to speak to be heard. I'd just like to remind you about that.

Mrs Papatello: Jack, you keep your members in line and we won't have a problem.

The Chair: Thank you, Mrs Papatello.

Mrs Papatello: They have a responsibility when they sit there on the government side.

The Chair: Mrs Papatello, I just made a suggestion.

ONTARIO COLLEGE OF FAMILY PHYSICIANS

The Chair: The next presenters are the Ontario College of Family Physicians, represented by Dr Lynn Nash, the president, and Dr Ralph Masi, the president-elect. Good afternoon and welcome to our committee.

Dr Lynn Nash: Good afternoon. Thank you for the opportunity to address you today. I'm a family physician providing full-spectrum care to my patients and I practise in Ancaster, Ontario. I'm also the current president of the Ontario College of Family Physicians.

With me today is Dr Ralph Masi, who is a family practitioner from Downsview who, as well as having a broad-spectrum practice in family medicine, has a special interest in multicultural issues. Dr Masi is the president-elect of the Ontario College of Family Physicians. I ask you not to look at Dr Masi's hands today. He called me in a panic on my cellular phone because he had a flat tire coming into London. He of course had all the written material in his car with him, so he had to change his flat. His hands are clean when he's in the office.

You should have the documents in front of you. Because there isn't an overhead today, the green sheets in your packet will be a substitute for any overhead presentation, and I will direct you to the appropriate pages at that time.

The Ontario College of Family Physicians is the provincial affiliate of the College of Family Physicians of Canada. It's a voluntary organization of over 5,200 family physicians across the province who are committed to the promotion and further development of the principles of family medicine within the province.

Membership with the college is voluntary. Certification with the college requires successfully completing certification examinations, a minimum of 50 hours of documented study credit annually and participation in ongoing continuing medical education. The Ontario college represents family physicians working in diverse areas, including the geographically isolated inner city, suburban and rural areas.

I'd like to talk a bit about the primary health care infrastructure in Canada. Canadians enjoy one of the finest health care systems in the world. One of the strengths of the Canadian health care system is its exceptional primary health care base. In 1990, in *National Health Systems of the World*, Milton Roemer studied the distinctive features of health systems in 68 countries. This work and others show that the characteristics of the Canadian system are consistent with those in other industrialized countries. Users of the Canadian system have shown the highest level of satisfaction of any of the health systems studied, and I would ask you to look at the second page in the document with the green cover. There is a graph there that shows the comparative levels of satisfaction with the health system.

Notwithstanding indications made by the Minister of Health in his backgrounder of November 30, 1995, the success of our health system is not simply a matter of money. Canada has had the highest cost satisfaction index of any developed country, and that graph is within your document today. The Netherlands, with the second highest, also has a strong, well-trained family medicine base. Why is it that many countries around the world are seeking the assistance of family medicine practitioners and educators to assist them in developing their own primary care systems modelled after the Canadian system?

The question of the need for reform is before us. As a society matures, there is merit to evaluating and re-evaluating our health care needs and to reshaping the system to better utilize existing resources. However, reform implies that we build upon current successes. Enacting sweeping legislation that virtually imposes government control by eliminating collective bargaining, due process and overriding the principles of natural justice is not the means by which a democratic jurisdiction can achieve meaningful and lasting reforms. Reforms cannot be motivated simply by the need for cost containment. Fiscal responsibility must be balanced with consumer and patient needs and the principles of care. These principles provide that primary care should be comprehensive, continuous, community-based and patient-centred.

We agree with the ministry objectives of achieving cost-effective use of health care services. However, solving problems relating to physician distribution and consumer and provider accountability requires goodwill and the buy-in of all consumers, providers and the government working hand in hand. In the long run, this will ensure the availability and the sustainability of a broad-spectrum health care for all communities in this province.

We've identified some of the long-term impacts of Bill 26 and we've identified a number of critical concerns

arising out of the powers introduced by the proposed legislation. A number of these, such as the issues relating to obstetrics, the loss of patient-physician confidentiality and the abrogation of due process and natural justice, ie, arbitrary decision-making, no collective bargaining and no appeal mechanism, have already been addressed by others, and we will not dwell on those concerns but lend our voice to those others.

In the brief time permitted, we would like to focus on other issues which have not received such broad public attention. One of them is the politicization of health management. Traditionally, health care planning has been the responsibility of communities working to meet specific regional health needs. This has been a tremendously effective process which ensured that allocated resources would be utilized according to the priorities determined by the community itself.

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Under Bill 26 the minister will have the right to arbitrarily allocate and manage local community health. Accordingly, the emphasis on health management will be through the political process, rather than by local health planning. Do we want to create a system in which political lobbying determines funding and the delivery of health services?

With regard to physician distribution, in making decisions about physician distribution, we must ensure that the figures we base our planning upon are accurate. However, figures utilized in the government backgrounder are only very general estimates. The raw data fail to take into account such issues as type of practice, spectrum of care provided or even full-time versus part-time physicians.

Moreover, as Graham Scott pointed out, maldistribution is more a function of lack of support and backup. Rather than being assigned to rural communities where these problems remain to be addressed, over 65% of family medicine residents polled recently have indicated that they would emigrate to smaller communities in the US where these issues have been addressed. Clearly the problem is not a physical relocation.

We agree with those who recognize that no one works well under stress. By ignoring the underlying problems and enforcing redistribution through punitive measures like restricted billing numbers, you are creating a lose-lose situation in which neither the public nor the profession is well served.

What are the alternatives to achieve reform? Over the past several months several important initiatives to achieve sustainability, accountability and availability of health services have been undertaken. These include the Scott task force addressing rural and emergency issues, the Connell task force looking at funding and delivery issues, and many others.

Solutions are at hand that do not require the introduction of sweeping ministerial control. Solutions such as consumer selection or rostering or registration—which ever terminology you prefer—modified/alternative reimbursement mechanisms, identification of health targets and multidisciplinary approaches have all been tabled and thoroughly discussed to remedy in an equitable and just fashion the problems that Bill 26 purports to address.

The OCFP has been an active and willing partner, along with many other groups, in developing many of these solutions. In 1995 the Ontario College of Family Physicians published two documents: *Bringing the Pieces Together* and *Beginning the Process*. Both of these papers you have today. Both papers have been well received by the profession, the public and the government ministries, as responsible and practical proposals to achieve the needed reforms. To date, over 80% of our membership supports and agrees to the proposals for change outlined in these papers.

In summary, there's no question that there's much goodwill and many willing partners prepared to work together to effect the needed changes. Much has already been accomplished, and while there is much that remains to be done in terms of implementing needed reform, the broad, sweeping powers introduced by Bill 26 are counterproductive in the long run. Indeed, it is only through partnerships and collaboration that the success and the continuation of the high rating of our health system are likely to be maintained.

Thank you once again for this opportunity to speak with you. In the time remaining, we'd be happy to answer any questions you may have.

Mrs Ecker: Thank you for an excellent presentation. I appreciate the time you've taken and the work you've done to make sure you got here, flat tire or not. So thank you for some very excellent suggestions.

You make a suggestion in here about the fact that the profession now seems more prepared to look at things like rostering and alternative payments and issues of that kind. In terms of rostering, as I understand it, where you basically sign up with one physician and that is your physician, given the fact that we've seen, and physicians have told us, that one of the pressures they see in the system is people making use of walk-in clinics, for example, and then repeating the visit back to their own family doctor—or the data also indicate that there's a lot of, I guess physicians would call it, doctor shopping going around. One of the statistics I've used before is that in one month 7,000 individuals in Ontario saw five or more family physicians in one month, which I think you would agree was a little excessive. What is the best way to ensure that consumers are, if you will, complying with a rostering system?

Dr Nash: Primarily through education of consumers, and certainly we'd like to see a lot of education of the consumers in this province go forward. There is no doubt that you get better health care if your health care occurs through a central either physician or clinic. I would put to those consumers or patients that moving around for different care is really not doing themselves a service in terms of their own health care needs.

I think also you have to educate the public about the concept of rostering. We did focus groups in the province with patients, and it was very clear they really didn't understand the term "rostering." That's why we've called it patient selection. Primarily they need to know they have choice, and we believe you that should have the choice of your primary health care giver, that that should be the central starting point.

Dr Ralph Masi: You should keep in mind that once the consumer selection process is in place, there is

responsibility for physicians to be part of a network in which after-hours care is provided. But there would be a penalty involved for both the physician and the consumer for those who are seeking care outside their primary care source.

Mrs Ecker: As an organization that, if I say, has been sort of one step outside of the negotiations and some of the issues this government and previous governments have been wrestling with—the family college is kind of a little outside some of that pressure—would you like to give a comment about how you see the OMA-government negotiating process, how that has in the past met the needs of physicians and the needs of consumers?

Dr Masi: Basically, we feel we are members of the Ontario Medical Association. I don't think we believe that anybody's going to be well served by the profession being fragmented out into separate sections. We've been working with the OMA over the last number of years, and certainly much more so over the past year, to ensure that the voice of family medicine vis-à-vis primary health care gets through. We'd like to see that that voice is clearly and solidly heard in the process of negotiations, but we do believe that the best process is where one organization negotiates for the entire profession. We don't want to see splinter groups.

Mrs Ecker: One of the things the minister has been well aware of and acknowledged is that in order to get physicians into underserved areas, there has to be a multifaceted approach. As many reports, as you note, have recommended, he has talked about the incentives through the education, through locums, through CME opportunities etc, and if in the last resort you needed some stick, the billing numbers would be the stick.

Can you elaborate on some of the comments you made in your report, since the committee's just seen it, that might address some of the underserved areas challenges that so many governments have wrestled with over the years and none of us has managed to solve yet?

Dr Nash: I think it's going to take a great deal of time. We now have residents in the province in family medicine who are being trained in the north. It's very clear from that experience that they are staying in the north to practice once they become comfortable with their skills, because there's no question that if you're practising in a rural practice, you don't have the backup you have in the urban centres in terms of technology and specialists etc and you have to have a comfort level there.

I think that over time you will see more physicians choosing to be there because they're comfortable there. It's very clear that the people in those areas, the patients, would like to have physicians who are happy to be there, who want to be part of the community, as opposed to physicians who are only sent there because they have to.

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Mrs Caplan: Actually, I appreciate your answers to the government caucus, because I think you've identified the real crux of the problems of Bill 26. While you are an organization that has no official negotiating status, as was properly pointed out, the college of family practice is not only as well respected but you've had a relationship with the Ministry of Health and have been consulted on policy over the course of time. I know that because I consulted with your organization myself.

This report, *Bringing the Pieces Together: Planning for Future Health Care*, was printed in March of 1995. That was prior to June of 1995. It was prior to the tabling of Bill 26.

My question is, given the fact that this is out there, that your recommendations are very significant restructuring, were you consulted by this government as to what it was proposing in Bill 26?

Dr Nash: No.

Dr Masi: We've had a request in to meet with the minister and we have not yet heard back from the minister.

Mrs Caplan: He hasn't even met with you?

Dr Masi: No.

Mrs Caplan: I didn't expect that answer. I can't believe that he wouldn't have agreed to meet with you.

Ms Lankin: Elinor, you never ask a question you don't know the answer to.

Mrs Caplan: No, I must admit I'm surprised.

Your second report is out in December of 1995. That's just last month. I know that not only 80% of your members support this proposal, but I understand it is also supported by the Ontario Medical Association.

Would you like to see Bill 26 changed so that this became the model for primary care reform, or do you think that it should be done in a separate piece of legislation apart from Bill 26?

Dr Masi: I think the two processes are somewhat different. I think the changes involved in Bill 26 far supersede anything in terms of the focus of this, but certainly I think that the work represented by these two papers and the specific directions are not addressed directly. It bypasses it, and it kind of uses the push or the coercion approach as opposed to the partnership, which is there. It's evident; it's plain. We're willing to talk. You don't need the hammer.

Mrs Caplan: And Bill 26 is the hammer. If they were to withdraw those sections of Bill 26 which are most offensive and coercive, do you think there's a spirit out there where you could come together in partnership and implement something like this? Is that still possible if they withdraw those sections of Bill 26?

Dr Nash: I think it is. I have a great deal of optimism for the future of primary health care in this province, if we can build a partnership.

Mrs Caplan: What'll happen if they don't change Bill 26?

Dr Nash: If they don't change Bill 26, we know the physicians in this province will leave in droves. There's no question. Recently, a reporter said, "Well, is that sort of not just saying we will take our toys and not play any more?" It's the reality if you look at the numbers of physicians who are now being wooed to south of the border.

Dr Masi: Not only that, I think you're going to lose a tremendous amount of goodwill by people who are willing to work. You don't have to twist their arms, and once that starts happening, I think you'll start taking stands and I think you'll see more dissension and less willingness to work together.

Mrs Caplan: Well, I hope they've heard you, and I hope the minister will meet with you. In fact, I'm going to table a question, Mr Chairman, and ask if the minister

will notify this committee of a date when he will meet with the college of family practice prior to the passage of Bill 26, which is contemplated on January 29. I think the committee would like to know the minister has at least met with these people, who have a very good alternative, and while you're drafting amendments and proposals, my request is, is the minister willing to meet with them, and will he do so prior to January 29?

Mrs Boyd: Thank you very much for your presentation and for all the work that's gone into the background materials that you provided for us. We heard Mrs Ecker say on behalf of the government that indeed these are problems that have been around for a long time and they haven't been resolved, and the implication was that they weren't being resolved because physicians weren't prepared to work on them. I think I hear, certainly from you and from other physicians who have appeared, a real resentment of this notion that all of a sudden martial law, as a former presenter said, in health care is required in order to get changes.

I think you know, and many of us know, because of the work that's been done before, what kinds of other supports physicians look for in these underserved communities in order to find practice there attractive. Certainly the PCCCAR report and the Scott report and so on have detailed those. You don't detail them in your presentation, and I think it would be helpful to just name some of those, in view of the community members who are bringing forward their own ideas. What kinds of supports are lacking in underserved areas that family physicians see as being more available in small and mid-size American cities that would encourage them to leave Ontario and go there to practise?

Dr Nash: I hear from many physicians who have looked at those smaller communities here that there's a lack of specialist support. If you look at many of the smaller communities in the US, they're able to attract their primary care physicians because they do have that physician backup, even when it is in a small hospital that may only have 100 beds or less than that.

I do think it's naïve, though, to look at it primarily in only a medical context. We now have many more physicians who are female practising. The majority of physicians have spouses who have a job or a profession, and it's not as easy to just pick up and go. I've heard many physicians recently say that indeed if they were mandated to go to one of these communities, much as they would like to, their families couldn't just go with them and it would mean actually for some stopping doing medicine. That's very sad to me when you look at the great resources that we've produced.

I think communities have to look at how they can attract physicians and their families. If you look at the successful communities out there, they attract the physician's family. If you're married to a teacher, they say, "Fine, we'll ensure that you have a teaching job." The US is doing that as well.

Mrs Boyd: So the multiplication effect, then, of all of the things this government is doing in Bill 26 and in other policies is going to impact very seriously on those things: effects on education, effects on the social services

that are available, effects on the community services that are available, user fees in order to enjoy those community services; all of those will impact.

One of the questions that we asked this morning, one of the issues that we asked of University/Victoria Hospital, was even the lack of support for things like LARG*net, which has a great capacity to offer distance, immediate specialist advice to physicians in remote areas. Even ONIP, the program that funded that, has been cancelled.

So what we are doing is essentially saying on the one hand we're going to make physicians work someplace, and then on the other hand, with every policy that gets passed by this government, making it impossible to attract physicians to stay in our province and indeed in those underserved areas. Am I right?

Dr Nash: Yes.

Dr Masi: I think we also have a concern that taking the approach of having the sort of backup "We will assign" will take the emphasis or the focus off the larger issues that are really the problem—the family, the support structures, the working hours—on the simplistic understanding that: "Well, we'll just assign people. That's all we have to do."

Mrs Boyd: Private industry is expressing the same concern, that if the quality of life, which is often the one thing they can use to attract people to move into the communities where they want to do business, is missing, they won't be able to attract people either. So this is a widespread concern, and one that you would find has great resonance with the larger population.

My last question would have to do with the question of retiring physicians and this issue of not being able to sell a practice if indeed you do retire or if indeed you move. I wonder if you'd comment on how that affects particularly family practitioners—and their patients.

Dr Nash: There's no question that it affects both family practitioners and their patients. Family practitioners are very bonded to their patients. We have a relationship with our patients that occurs over years, and quite often, such as in my own practice, I have generations where I look after grandparents and grandchildren etc. It's very, very difficult just to leave those patients without any care at all. The impact in terms of physicians is that there are no physicians out there who would take over that practice. With the present constraints, I think you'd be crazy as a young physician to buy a practice, frankly.

The Chair: I must say, just as a little aside, you win the prize for the most musical interludes during your presentation, thanks to our chimes. Thank you very much, doctors. We appreciate it.

1400

LONDON LIFE INSURANCE CO

The Chair: Our next presenter is London Life Insurance, represented by Jim Etherington, the vice-president of corporate affairs. Obviously, Mr Etherington is not alone, so I'd welcome you all to our committee and ask you to introduce yourselves for Hansard, please.

Mr Jim Etherington: I am Jim Etherington. I'd like to also introduce Jim Connor, who is market manager of

our employee benefit division, and the presenter today with me, Mrs Kim Noble, manager of health and dental products for the company. Although we're handing out copies of the Globe and Mail excerpts, this is a different Kim Noble.

Mrs Kim Noble: Mr Chairman and members of the committee, we're here today to address the changes to the Prescription Drug Cost Regulation Act, specifically the deregulation of drug pricing.

As background before I begin, you should be aware about London Life. London Life has over 4,200 health plans in Ontario which include prescription drugs as a benefit, we cover over 250,000 employees as well as their families in Ontario, and we pay over \$52 million in drug claims each year to Ontario residents. We've incurred the same kinds of cost growth that the government has experienced on the ODB plan. We know the problems you're dealing with.

We support the minister's goal of controlling cost growth in the ODB program. We want to ensure that you're successful at doing that. We think that you need to make one amendment now and delay the introduction of the drug price regulation until at least the fall. Those are our two key recommendations.

If we read this bill correctly, the minister's intention is to encourage free enterprise and to allow competitive market forces to keep drug costs down. However, we believe without question that drug prices are going to increase. It could take six months to five years before the market forces start to kick in to have that positive effect on drug pricing. In the meantime, the immediate impact is on the non-ODB consumer, who represents 75% of the people in Ontario who purchase prescription drugs.

Let me refer back to the environment in the mid-1980s, prior to when drug prices were regulated, to help us understand why what was done was done. The reason for government intervention in drug prices from the very beginning was that the public believed prices were excessive and there were repeated calls to the government to do something. That was true in 1974. It was true in 1984.

Some members of the committee will remember the Gordon commission of 1984, which examined cost growth problems in ODB. The program had grown to an astounding annual cost of \$350 million. Drug prices—specifically the spread between the cost to the pharmacy and the cost to the consumer—were the cause for public outcry. That's a very important point to keep in mind. The commission report said, "The Ontario drug delivery system operates to the benefit of all except the consumer and the taxpayer."

Just to reinforce those points, we did an on-line search of media coverage from a decade ago on this very subject. To refresh your memory, we brought along a small package of a sample of the articles from that time showing the tremendous public concern about drug prices. There are a lot to choose from. We just took a few to make a point. These are from the Globe and Mail during the period just before the Ministry of Health introduced the Prescription Drug Cost Regulation Act. So I'll quickly go through a couple of those.

From August 24, 1985: John Gordon, dean of the business school at Queen's University and head of the Gordon commission of 1984 said: "If we still believe in some sort of market economy, then the government had better start acting like it is a player. It seems that the government has just been rolled over by the other parties. And what really disturbs me is that it has not been representing the consumer and the taxpayer." That's the environment we were dealing in.

September 5, 1985: The Minister of Health, Murray Elston, said: "In theory the consumer exerts some pressure [to keep the total price down], but pharmacists have a self-imposed ban on advertising. It is somehow perceived to be a danger to the public's health if people know the price of prescription drugs."

Finally, September 24 of that same year: "The price of filling the same prescription in the Toronto area can vary by more than 100%, a Globe and Mail study of pharmacies has found.... Almost all surveyed pharmacies that charged the higher drug cost also charged consumers a dispensing fee above the legal limit."

The government of 1985 introduced the Prescription Drug Cost Regulation Act in response to legitimate public concerns. It seems prudent to consider these concerns when undoing that act.

We have come with a set of assumptions and with a set of experiences and history. The focus of our concern is on the non-ODB consumer who may or may not have insurance for their prescription drugs. Bill 26 will require the consumer to take on a new role, a role as a smart shopper, but this consumer will not have the tools to do that effectively. Who will be available to help the consumer meet this new role?

On the one hand you have the role of the insurer. At London Life, we believe our role is to act as an intermediary on behalf of employers who want to offer personal financial security to their employees. We have no direct relationship with employees. Everything we do is driven through employers and at the request of employers.

On the other hand is the role of the ministry. We believe, given the minister's responsibility for public policy, you have to understand the ripple effect of deregulation of prices. That will affect the 75% of the population that are not on the ODB plan. For example, this committee has already heard from some employers who plan to drop their prescription drug plan.

An insurance company cannot negotiate out of that. That is an employer decision. The end result is that all individuals will pay more out-of-pocket expenses for medicine and become candidates for the Trillium plan.

Given these two different roles, I want to ask the committee, who do you think is in the best position to make sure that drug prices do not escalate unnecessarily?

Maybe it's a good idea to look at what factors will drive the total price of a drug after Bill 26 is implemented. There are three things. First is the actual cost of the drug, secondly will be the markup by the pharmacy, and third will be the dispensing fee.

The dispensing fee has been posted and competition has worked so the consumer can make an informed decision. After Bill 26, the other two factors, actual drug cost and pharmacy markup, become variable, and they

can vary from one pharmacy to another and from one plan to another.

Consumers cannot make an informed decision unless they know how their total drug price is going to be calculated. Therefore, they need to know exactly how their local pharmacy is going to set its price by the pharmacy posting its markup. We recommend this type of transparent pricing policy. And understand that it's not solely just on a receipt—okay?—that a consumer purchases the drug, comes home and later notices what the markup was. It's very important to stress that you need to know it at the time that you purchase the drug.

Purchasing prescription drugs is not like buying furniture. It's not where you can buy it today, take it home, comparison shop for a better price and then return it later. Drugs are not returnable. The consumer has one chance when they're purchasing the drugs, one chance to shop wisely. They need the information then to make the best decision.

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Without these consumer tools, we believe the impact of an unsuccessful implementation of Bill 26 will be felt by the non-ODB consumer, which again is 75% of the population.

We believe there are three parties impacted by this. First is the consumer. Consumers without information or tools to protect themselves from high drug prices will not become the expected market force that we need them to be to create competition. Consumer pressure needs to be targeted and focused in order to have an effect. They have to be able to compare the different elements.

Secondly, employees will be impacted. Drug plan costs will increase, resulting in employers either cutting back or eliminating their drug plans or passing higher premiums on to the employees. Understand that the employers will drive that. The bottom line is, though, there's more money out of an employee's pocket.

Finally, the third party impacted is the government. What you'll see, first, is a higher number of individuals become candidates for the Trillium plan. Secondly, you'll see an increase in public complaints. Finally, you'll have no more access to information than consumers do to understand why drug prices are increasing. You won't know where the problem lies, because in effect we've hidden the responsibility and the accountability for drug pricing increases. That's why we support a transparent pricing policy.

As I said in the beginning, I wanted to make two points. Number one, we strongly recommend a transparent pricing policy for all prescription drugs. Secondly, you're counting on London Life and other providers to become a negotiator in a way we've never done before. If you're counting on us to exercise a new market influence in a way we've never done before, if you need us to take on a role with manufacturers and pharmacists in a way we have never done before, if you need us to do those things, we're willing to do them. But we can't do them by January 30; we need more time. I can't imagine putting all of those things in place to be successful in less than nine months.

Our responsibility is very much like yours. We have to serve the public interest. We need the tools to do that. Thank you very much.

Mrs Papatello: We talked to the district labour council for the London area. We talked about the changes in drug prices and services in health that now won't be covered, and that in fact that puts the onus on the employer, because it becomes a negotiated benefit. The likelihood is, too, that the employer can then in turn go to their insurer, such as yourself, and say, "I'm not paying any more premiums." It becomes a war among you and your competitors for who is going to provide the additional service coverage at a minimum premium to the employer.

I should ask the government members, I guess. In this, you know, free-for-all, pro-business stuff, how come you don't like that? I mean, you're business. You should appreciate this free-market glorious way to make money.

Mr Jim Connor: There are a couple of things you have to recognize in the 4,200 groups we represent. We represent from small groups right up to large groups. A large block of our groups are 3,500, and it can be down to three lives; in fact, they shrink down to two lives. In addition, the people we use to give counsel and advice to the employer cannot completely understand the whole drug mechanism the way it is, so we try in our dealings with the employers to keep the conversation about drugs, which Kim knows inside and out—it's fairly high-level. Deductibles coinsurance is an area we work at. Dropping down to picking individual drugs at an individual level not only gets us into privacy issues, but is well beyond the scope of our distribution system. Those things we have to be sensitive to when designing plans.

Mrs Papatello: I guess the simple answer to a simple question is that at the end of the day, with these changes in these services, it's going to be you who pays for them, because you won't necessarily have the ability to show the employer how he should pay. You're going to end up having to cover more and still try to maintain an optimum premium level.

Mrs Noble: Are you talking specifically about drug pricing or the other portions of the bill that—

Mrs Papatello: I'm thinking of general services you are going to cover as an insurer.

Mrs Noble: We will give employers tools to decide if they choose to take on pieces that are no longer covered under an old—

Mrs Papatello: So employers will pay.

Mrs Noble: We will give them the tools to decide which way they want to go. If they want to control their prices and keep them down, they may choose not to take on those pieces.

Mrs Papatello: If they maintain the same level of service to employees as a benefit, the business will pay.

Mrs Noble: That's right.

Mrs Papatello: Just so it's on record that the business will pay. For a party that is supposed to be in favour of business and not incurring additional cost on business, I would think this kind of bill is really bad for business.

Mrs Noble: I would just like to add that it may be the employee who pays. The cost of those premiums could go to the employee as well.

Mrs Caplan: Or they may have access to fewer benefits.

Mrs Noble: Those are the two things you play with: Do I keep my coverage the same and pay more, or do I drop my coverage and pay the same?

Mr Sergio: You have alluded to the financial aspect of the situation. The way it is presented now, what the minister wants to do with this proposal is to not only deregulate the drug business, but also to create two classes of people. How does the deregulation of drugs affect these two classes of people? You're going to have one that can afford it and one that cannot. You will have two people going to the drugstore to fill a prescription. One will be charged one price; the other another price. How does that affect?

Mrs Noble: That's what we're trying to say: Make the customer aware that environment is going to happen and put the tools in their hands to say, what am I going to do about that? That they ask some questions, understand what is being charged, and if they have the privilege of having an insurance plan, understand how their plan will cover that or not cover that.

Ms Lankin: I appreciate how in-depth your presentation was and the research work you did. This is terrific. I'm reading through these press clippings from 1985. I had forgotten some of this debate, so it's very helpful.

I came across a quote from Ed Mirvish. Honest Ed's was a big pharmacy player and was very low-cost, high-volume so they could have a low price. It actually says in here at one point their prices were so competitive that people came from as far away as Hamilton to shop at his pharmacy at Honest Ed's in downtown Toronto.

In the debate we've been having, I've been having a very hard time understanding this part of the bill. We've had the pharmaceutical brand-name industry come and say, "Right on." We've had the generics say, "It won't work." We've had the pharmacists express a lot of concern and caution. Generally, responses from the government—and I understand what they're trying to do. They're trying to create competitive market forces and they believe that'll bring the price down. But in trying to determine who's going to drive that competitiveness, we realize that the large purchasers—government, which is still regulated; large plans, where they have that ability, and I recognize your point about the time it would take; or large chains, say Shoppers Drug Mart—have a capacity to bargain a price that small independent pharmacists don't, that small rural Ontario pharmacists don't, and, from the consumer point of view in terms of markup, where there's essentially a monopoly: one small-town pharmacist.

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We can't understand how there isn't at least the possibility that prices are going to go up, yet we keep getting assured of this, and we're told that the public will shop around. When you need drugs, many times it's because you're sick, and the idea of going from pharmacy to pharmacy to find the best price is a problem. If you have complicated medical problems, the flipside to how to save costs on drug plans is proper pharmacological education and pharmacological counselling, which means one pharmacist working with a patient and knowing the interaction of their drugs, their medication program and the diagnoses from the doctor and the prescription. These are the myriad questions I have.

As opposed to what we have now where basically drugs are essentially a one-price policy for the generics and the brand-names, do you see the possibility for differences in price in terms of what they're going to sell at to the pharmacies, and then differences in terms of the pharmacies' retail prices based on size of chain or location?

Mr Connor: We get different prices today with the pharmaceutical association and the manufacturers. We're the only one in this business with the end price of anything. They all ship it out their door, put a markup on it, and it may be different all over. We get a different price for the same drug today. We're the only ones who have that information because we pay the bill. There are different prices today for the same drugs. What you've got is some control in your mechanism to say it can only go this wide, but that's a 20% width. Think of it today. We experience paying through an employer a 20% difference in one price of drug to another, plus a dispensing fee.

Ms Lankin: Now, 20%'s a lot, so that spread's there. If competitive forces were going to work to bring costs down, why wouldn't they have at least reduced the possibility of that spread or the consumer shopping around? I guess it's the transparency issue you raised.

Mrs Noble: That's right. You don't know. There are three pieces to that, three things we know today. We can shop around, we can look on the log and say: "That pharmacist charges me \$5. This one charges me \$11. For the \$11, I get 24-hour delivery, all kinds of things. It's worth it to me. Even if my plan only covers \$10 of that, it's worth it to me to pay the extra." That's the only piece they have to decide on.

In the future there may be two other pieces, mainly the markup. If that independent, around-the-corner pharmacist charges 15% markup versus another place that charges 10%, but I'm getting 24-hour delivery, that's worth it to me. If I understand that my plan is only going to pay 10%, I make a conscious decision on that 5% to go with that pharmacist or not. But that's part of what competitive forces are all about.

Ms Lankin: What an incredible shift to the public, though, in terms of this competitive process. Wow.

Hon Mrs Cunningham: Thank you for your presentation and good afternoon. In your list where you talk about the transparent pricing policy, assuming that includes the markup and the dispensing fee, has this ever been a request by the insurance companies in the past? I've been through two rounds of public hearings in the last eight years on the overuse of medication, the cost of medication. Has this ever been a request or a suggestion?

Mrs Noble: To my knowledge, no, but there have been the drug regulations in place to control price, so there hasn't been a need for this.

Hon Mrs Cunningham: I think it's been an issue. Although the insurance companies haven't asked for it, many other consumers have asked for it over the years during different hearings. There's no doubt that people want to know what the dispensing fee is and what the markup is. I must admit I hadn't heard very much about the markup, but certainly the dispensing fee was extremely controversial during almost any hearings we've had on

the cost of health care. That's why we are moving in this direction, because we feel that the cost of drugs is not only expensive to the public of Ontario, but we also think the overmedication of seniors is not effective for their proper health care. That's one of the solutions we've looked at.

You were asking for two things. What is the amendment you want?

Mrs Noble: The amendment is to provide transparent pricing, so therefore post markup, and indicate the actual drug cost as well as the dispensing fee.

Hon Mrs Cunningham: The second, of course, is to delay the deregulation piece.

Mrs Noble: The timing.

Hon Mrs Cunningham: And in the meantime, during this time of delay, if we want to sell this amendment to the government, what would be the three main messages with regard to the delay?

Mr Connor: If you don't delay it, you're going incur costs on your Trillium plan that you hadn't anticipated, because you won't have your negotiation done with the drug manufacturers. We're in the same situation. There would be variable pricing going on underneath the covers before you get a chance to get it in.

Hon Mrs Cunningham: But you're not here today to speak about deregulation per se. You're not against it?

Mrs Noble: No, we've not said that. We've said we need the tools make it successful and we've laid out what those tools are.

Mr Bob Wood: I gather from what you're saying that you favour the shift to the free market, that you have no quarrel with that. The invariable experience with true deregulation has been rationalization of prices and an overall drop in prices, the classic case being the deregulation of airlines in the United States; in 15 years air travel tripled and prices rationalized and overall went down. I gather you accept the validity of deregulating prices that ultimately will save money for the consumer.

Mr Etherington: What we would say is that if you're going to make it work, you have to put all the pieces in place to make it work right. What the bill is leading to at this point is a gap, and that gap is going to cause an increase in prices overall. As Mrs Noble pointed out, while there may be what you are anticipating that market forces will eventually kick in, it may not happen for three or five years, and in the meantime, people are going to have a zoo out there in terms of the cost of drugs.

Mr Bob Wood: I understand the transitional difficulties, but you accept the principle that a true free market will reduce costs to the consumers?

Mr Etherington: Yes, with all the pieces in place.

The Chair: Thank you for your presentation. We appreciate your interest.

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LONDON BATTERED WOMEN'S
ADVOCACY CENTRE

RON WEXLER

RAFFAELE FILICE

The Chair: Our next presenters, representing the London Battered Women's Advocacy Centre, are Julie Lee and Cheryl Champagne.

Ms Julie Lee: Mr Chair, I'm also being joined by some copresenters that I'd like to introduce to you. I will make my 15-minute presentation, and then I'd like to make the rest of my time available to colleagues, Dr Ronald Wexler, who is a board member with the Ontario Medical Association, and Dr Raffaele Filice, from Diagnostic Imaging Associates. Just to ensure that all of us get an opportunity to speak, I'd like to ask that questions be held until the end.

I'm making my presentation to you today in good faith, assuming that my input will be given serious consideration. I begin by asserting this because I am concerned that my input will be dismissed because of some assumption that I represent a special-interest group. So let me be clear about what interests I bring to this table and what constituency I represent.

I am paid as a professional in this community to work to respond to the needs of women who are victims of violence in their most intimate circumstances. In order to do this work, I can't work alone. This is why I work within a community context which has a history of over 16 years where agencies, professionals, judges, lawyers, police, mental health workers, children's advocates and women's advocates all come together on a regular basis to collaborate in addressing a serious social problem. Together, our special interest is simply that violence against women in our communities must end.

None of us doing anti-violence work comes to the work from a perspective that simply defends the continued expenditure of public funds for the sake of protecting the budgets of agencies. Our principles of accountability, which are on record, demand that we ensure that any expenditure of valued and scarce resources be directed towards our ultimate goals, our special interest: ending violence against women. Certainly it's our hope that one day there won't be a need for an agency like the London Battered Women's Advocacy Centre, but we're not there yet. In fact, we'll be the first to celebrate when we arrive in a community and a society where we no longer require this service.

In order to achieve our goal then, what we require is a great deal of planning and foresightedness. We need to think in terms of the long run and not in simpleminded short-run issue bases. This is why I'm so concerned about this new piece of legislation and indeed concerned about the overall approach of your government to fiscal and policy management. Your approach to date has been extraordinarily narrow and shortsighted, and indeed your policies and cutbacks represent major setbacks, not just cutbacks, in the long-term project of ultimately ridding our communities of violence against women.

Let me be specific about what our communities require in order to reach our ultimate goals and deal with violence against women in our community:

(1) In order to shift bad attitudes about violence and sexism and to work in the area of prevention, our communities require support to provide education. Your government eliminated all funding for prevention and education through agency provision in October.

(2) Violence affects all peoples with all of their diverse cultural and lingual backgrounds. Therefore, we require support in order to ensure that women and men who do

not speak English can access services and education. Your government eliminated funding for cultural interpretation services in the fall.

(3) In order to teach men who have been abusive to stop these behaviours, we require support from our government to offer professional counselling programs to abusive men. Your government eliminated Ministry of Community and Social Services dollars for batterers' counselling programs.

(4) In order to support abused women and their children to have a new fresh start in a life without violence in their lives, we require support for a transitional counselling and housing program, second stage housing. Your government eliminated all funding for the safety and counselling component of second stage housing through the province.

(5) Abused women require immediate and equitable access to a lawyer for advice and pursuit of justice. Your government has thrown legal aid services into a crisis in the last nine months because your Attorney General hasn't been paying the outstanding legal aid bills and because you have further constrained legal aid eligibility to low-income women. Abused women can no longer be assured that they will have due access to legal forums.

Finally, as I indicated earlier, in order for us to achieve our long-term goals, we need to be supported to come together to plan, coordinate and improve our strategies for ending violence. In the fall your government eliminated all funding for planning and coordinating bodies.

Prevention, education, treatment of batterers, transition programs for battered women, access to services in one's own language, access to basic legal services, planning, coordinating and collaboration—all essential ingredients in the recipe for community-based, positive social change—all which has been dumped aside by your government.

This bill further follows this path. It establishes a narrow and shortsighted approach to fiscal management. Ontario is in serious trouble when its government puts into place fiscal and legislative policy without considering the long-term goals of its people. Indeed, this legislation doesn't even take into account other important areas of concern related to the policy that you're setting. The best example of this contained in the bill is in your making vulnerable people's private case and medical records available to who knows who.

Is this government completely unaware of the ongoing national crisis with respect to the disclosure of abused women's private counselling records? It appears so, because you fail to take into consideration the full complexity of the matters at hand. You cannot continue to proceed in creating fiscally convenient policies without a full consideration of the interaction between legal and social issues.

Let me be specific about what I'm asking you to consider. In the last couple of years there have been increasing attacks on women complainants in violence-against-women legal proceedings in both civil and criminal courts. To be specific, defence lawyers are engaging in a strategy stridently named by themselves "whacking the complainant." Their strategy, actually documented and published in the *Lawyers Weekly*, is to

subpoena all personal records, including diaries, of a woman complainant in order to shake her up—this is their language—in order to defame her character and credibility and to dissuade her from proceeding with her testimony in pursuit of justice. As soon as the records are subpoenaed from an agency that has been acting to support this abused woman, she is no longer in a situation where she can access those services, because her counsellor becomes a witness in a criminal proceeding.

The results of this hostile treatment of women victims are already being felt in communities across Ontario and Canada. According to research done in Barrie, Ontario, since this new strategy has become more dominantly practised there has been a 38% decline in the numbers of sexual assault victims coming forward for service. This is a serious decline, especially when you recognize that women are already overwhelmingly hesitant in coming forward for service. In fact, only 5% of victims are recorded, given national data, as coming forward for service. They're afraid of humiliation. They're afraid of stigmatization. Your bill further escalates this risk to battered women. Women's ability to come forward for help and support is now under attack from two fronts: in the courts and in the doctor's and counsellor's office. Where can women turn to for private, confidential, safe support when they've been abused?

In summary then, we're calling upon this government to immediately halt the approval of this bill until there is due and full consideration of the implications and consequences of this legislation and how it interacts with other important areas that are currently being debated and attempting to be resolved. Furthermore, you cannot begin to understand the full impact of this bill without ensuring that a truly inclusive and democratic process of consultation is undertaken. Given that principle, I'd like to ensure another voice that hasn't been heard is heard for the last part of my section. Thank you very much.

Dr Ron Wexler: Good afternoon. My name is Ron Wexler. I'm a physician who has practised anesthesia and intensive care medicine at University Hospital here in London since 1975. I am presently on the board of directors and on the executive of the Ontario Medical Association. With me today is Dr Raffaele Filice, who is a London radiologist and also holds an independent health facility licence in radiology.

First, I would like to thank Julie Lee from the London Battered Women's Advocacy Centre for so kindly offering part of her time to us this afternoon. I will try to keep my remarks brief and to the point.

The area I wish to explore with you today is the Independent Health Facilities Act and the changes that Bill 26 proposes to make to this legislation. I will first begin by outlining how the act originated.

The Independent Health Facilities Act was passed in 1989. It was originally designed to regulate the provision of private medical services that had a significant technical component in a non-hospital setting such as radiology clinics and outpatient surgery facilities. It provided a mechanism for the quality assurance of such facilities and also provided a way to fund the facility's technical costs, such as those required for equipment and staff. This became necessary following the passage of the Canada

Health Act which prohibited the charging of any facility fees directly to patients.

IHF's, as I'll call them because it's easier, presently are thus only granted where a high technical overhead exists. Bill 26 would change these criteria to allow the Minister of Health to designate any private physician's office practice as an IHF. This is obviously a major change that has nothing to do with the original intention of the act.

At the present time, an IHF can only be shut down during the term of its licence for patient safety reasons. These facilities are then inspected every five years at the time of licence renewal, and the renewal of a licence can only be denied at that time unless, as noted, there's a safety factor during its existence.

The changes proposed in Bill 26 would allow the Minister of Health to revoke a licence at any time, not just at the end of the term, without a stated reason. There would be no appeal from this ministerial decision. The result of these two changes, the indiscriminate designation and the unappealable revocation, would lead to the minister being able to shut down any physician's private practice with no notice and no appeal. To my mind, this amount of power in the hands of the minister is unacceptable. The minister has not indicated why he feels that these extraordinary powers are necessary, and I for one cannot fathom it either.

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Bill 26 also determines by legislation that the minister can declare a service provided by an independent health facility to be nil—that is, zero—but does not remove that service from the OHIP fee schedule. This means that while there's no fee paid, there can be no charge rendered to the patient either, though if you provide the service, you don't get paid and if you don't get paid, you can't afford to provide the service. This bill also states that the value of an IHF licence has no value on transfer to another holder.

As you can imagine, these issues will make it very unappealing for individuals to hold IHF licences because they will never know for certain if they can afford to operate them, and if they cannot recapture any of their capital costs when they wish to transfer them, they will basically give up all of that investment. The cost to set up some of these facilities can exceed \$1 million in some of the sophisticated diagnostic facilities, and the units may employ upwards of 20 people. We're not talking about small potatoes here. Every person presently holding an IHF licence will live under a continuous cloud of uncertainty, never knowing if tomorrow the licence will be arbitrarily revoked.

It is of some concern that with these changes Bill 26 also permits the minister to request a proposal from any specified individual. Presently, the Independent Health Facilities Act prescribes an open system that does not limit the number of applicants who may respond to a proposal. Why would we eliminate competition which provides the highest quality, most cost-effective services for the people of Ontario? These changes to the IHFA, the Independent Health Facilities Act, will without a doubt take us back to the days of open political patronage.

Finally, the Independent Health Facilities Act provides that the government give preference to Canadian citizens, landed immigrants or Canadian-owned corporations. Bill 26 removes this requirement, so that licences could be granted to foreign individuals and corporations. This proposal would have a negative effect, in many ways, on the Ontario economy. I feel that licences should be given to Ontario applicants, in particular Ontario physicians, who would be responsive to the clinical needs of their patients. Furthermore, the granting of licences to foreign operators would in fact cause Canadian dollars to flow out of the country.

I would now like to ask Dr Filice to comment on how he, as an IHF holder of a licence, feels that the changes in Bill 26 would in fact affect him.

Dr Raffaele Filice: From Dr Wexler's summary, it's not difficult to imagine the potential repercussions of implementing the regulations outlined in Bill 26. I am a radiologist practising primarily in an independent health facility. I have two offices and employ approximately 20 people.

Like most facilities, there is a sizeable capital investment. More importantly, however, is the fact that we provided health services with approximately 60,000 patient visits in 1995 in a professional, friendly, safe and efficient manner.

My staff and I are dedicated and proud of the work we do. Our facility has passed the College of Physicians and Surgeons of Ontario independent health facilities assessment for licensure, a quality assurance program with some of the most stringent criteria of any other jurisdiction in North America. The Independent Health Facilities Act has met its mandate of promoting excellence in the delivery of health care services.

The reasons for the proposed changes to the Independent Health Facilities Act, however, leave me at a loss. Why? I keep asking myself why the Minister of Health wants arbitrary and absolute power over such essential health facilities. Why does he want to be able to close them down with impunity? Why does the Minister of Health want us to work with this axe over our heads? How is this type of approach going to increase consumer confidence and create a climate for investment and job creation? This doesn't make sense to me.

You may have seen this document. Mr Harris was pushing this document. It's the Ontario PC Party's Common Sense Revolution. I thought this meant the application of common sense to governing. Instead, it's beginning to appear that the Common Sense Revolution actually means revolutionizing or redefining the meaning of common sense.

In conventional terms, common sense may be exemplified in the following ways. If your car breaks down, call a mechanic. If your house catches fire, call 911. If you have chest pain, go see your doctor.

The new PC Party definition or application of common sense might lead you to look at it this way. If your car breaks down, call a dentist. If your house catches fire, have a public hearing. If you have chest pain, call a bureaucrat.

Reforming health care by cutting doctors out of the process doesn't make sense. More government is not

what we were promised in the Common Sense Revolution. A government with common sense is what we voted for, want and expect. Please reconsider what you're doing with Bill 26, or at least explain to us, the citizens of Ontario, what your reasoning is behind it and what your vision is for the future.

Ms Lankin: I appreciate the comments you've made with respect to changes under the Independent Health Facilities Act. I don't have any specific questions on that. My questions, actually, like yours, are of the minister and what it is he wants to do with these powers. But that's true of so many aspects of this bill. We do hear assurances from government members of what the intents are, but that isn't written into the legislation.

Dr Filice: It's not reassuring.

Ms Lankin: That and a quarter will get you the same.

I use this example a lot, but one presenter in Thunder Bay said it's like the government is asking us for a blank cheque, but they won't tell us what number they're going to write in before they cash it. I think that's a really eloquent summation of it.

I want to address the issue of patient confidentiality, because I think in Ms Lee's presentation she underscored that and I think it would be an issue of concern to you as practising physicians, given that the records are there in your office, what kind of effect this might have on what you keep on patient charts and/or on patients' willingness to share information with you. I'd appreciate answers from any of you.

Mr Clement has, day after day, tried to convince presenters coming forward that the new language actually narrows the ability of the ministry to use private information. However, it just seems that's absolutely incorrect. The old purpose for looking at any information was to look at the services. It was related to the services provided, to pay them, and it was under the purpose of the act. Now it's for the purposes of payment, for the purposes of monitoring and controlling, for the purposes of looking at broader health issues and for any other purposes.

There's the whole range of inspectors' powers, not to go in and look at accounts, which if you are looking at issues of fraudulent billing, which they say is the reason, used to be the process. Now you can go in and you can take the actual health records, the notations, photocopy them and take them back. In the past there was no provision for the minister or the general manager to disclose it to anybody outside of government, and now you can disclose it. And, by the way, now the minister and general manager are immune from any prosecution. Those are all new things.

Could you just tell me what it means, first of all, because I think, Julie, you did express the concern, but from your perspective as physicians, what it means in terms of patients and what they'll tell you and what you'll chart down, and your concerns. Then if there's any time, you could add to it, Julie.

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Dr Filice: To me, it's a double-edged sword. When you're in a confidential situation between patient and doctor or lawyer and client, whatever the case may be, your freedom to speak is enhanced by the very nature of

that situation. Just like it would exacerbate the abused woman's situation, the same thing would apply when a patient comes to seek help from you.

The other thing that I see complicating the situation is that I have records on the patient. Technically, those records are the patient's, are about the patient, belong to the patient, and they have every right to determine what happens with those records. It's not really for me to decide. Yet the minister can come into my office and impose this on me, rather than at the very least going to the patient and saying: "Look, we're sequestering your records. How do you feel about that?" They bypass that whole thing.

So it certainly would encumber the patient-doctor relationship, and then also I feel, as a physician, that I am compromised by that arrangement. I would fight that.

Mr Bob Wood: I'd like to ask a couple questions of the doctors, and they relate to the question of cancellation of licences for IHFs. You would accept the proposition that if someone is not living up to the terms of the licence in the act, the licence should be cancelled. You have no problem with that, presumably.

Dr Wexler: I would accept a cancellation of the licence if it could be shown that the quality and safety of the services provided were unacceptable, of course.

Mr Bob Wood: So the issue that you really are bringing to us is, you don't like the way in which this is proposed to be done. You think it's too broad.

Dr Wexler: Exactly.

Mr Bob Wood: What I'd like to canvass with you is how you would repair that. For example, would you be satisfied if the legislation said it can be cancelled for non-compliance with the act?

Dr Wexler: I'm not sure what that means. Are you talking about the act? The regulations? When it comes down to a practice of medicine, I'm concerned about the quality of the practice of medicine and the quality of services. I'm not sure what nuances you're suggesting. Maybe you'd like to clarify for me some of the things you would consider as non-compliance with the act and then we can discuss it further.

Mr Bob Wood: Well, of course, there's non-compliance and non-compliance. It obviously depends upon the severity of non-compliance as to whether or not you'd reprimand a facility or actually—

Dr Wexler: I'm not sure. If I'm providing lousy medical care, yes, I'd better be shut down right away, real quick. If I'm providing good medical care in an appropriate manner, I'm billing appropriately for that medical care to the plan and I'm maintaining the various criteria that are required by the regulations of the act and the College of Physicians and Surgeons, ie, to maintain a quality assurance program, to keep proper records etc, then I would expect that the minister would not have the right, the power or anything else to shut me down.

I would expect that at the end of the five-year period, I would have a comparable physician from the college, as Dr Filice does on occasion, as my wife does in fact, go to the IHF that I own and have it reviewed carefully, intently. At that time, if my practice was up to snuff and everything met, I would assume to have another five-year extension of my licence. I would not want to be investing

money, time and hiring people and never knowing, one morning, if I happen to say something in my public persona that offends the Minister of Health, he can pull the rug on me. I'm not interested in that. I'm sorry.

Mrs Lyn McLeod (Fort William): I appreciate both presentations and I do want to acknowledge our shared concerns about the privacy provisions or the invasion of privacy provisions in this bill, not only in doctors' offices but also in independent health facilities and also in the ability to not only access but disclose information in relationship to the drug benefit plan—all without liability. We are certainly going to be pushing for amendments that would protect privacy in all those areas. We've heard similar concerns from HIV-AIDS patients and advocates concerned about whether or not they will come forward for voluntary testing.

I do want to come back to a question about the Independent Health Facilities Act, because it comes back to this whole question of the total control that government wants to exercise over the provision of health care in this province. You've raised all the questions we have not been able to get answers to either: why no reasons have to be given to close, what services are going to be shifted that are now provided only in independent health facilities that offer only insured services, what are going to be shifted out of existing facilities, why no RFP.

We're not in a court of law, and I'm going to invite you to speculate and make attributions, which I think you're allowed to do. I think it's a fair question, since we can't get any answers from the government as to what it intends to use these powers for. We've worried about Americanization, American companies coming in because the Canadian preference is lost. We've worried about whether this is a step towards much greater privatization, as we have a mix of insured and non-insured services delivered by one facility. You've suggested that there is also, because of no RFP, room for blatant political patronage.

The government has enormous powers in other parts of this act to control how many doctors, which doctors get to practise, where, who is an eligible physician. Do you see this as part and parcel of that, and what are your worst fears about where this may lead?

Dr Wexler: I have concerns about this. Like you, I have been speculating, had a few sleepless nights trying to figure out where this might be leading. I could speculate that by the minister having the right to designate a specific physician's office as an IHF, for example, and then turning around the next day and saying, "Now that you're an IHF, I'm shutting you down"—and regardless of whether anybody would or wouldn't do it, guys, it's there, and if it's there, somebody some day will do it. I don't want to hear from anybody that, "Oh, we wouldn't do it, even though it's there." It's there, it's possible.

If you considered an area was overserved, you can underservice that area very quickly by doing that. I thought that was kind of a neat trick. I don't know if anybody else came up with that little wrinkle or twist on it, but having worked it through, and worked it through actually with some of my legal colleagues, they say that would be perfectly possible to do. Of course, I wouldn't want to say that the minister or the Ministry of Health

would ever do anything like that. Raffaele, do you want to comment on that as well?

Dr Filice: What we're failing to understand is that while there was clearly opposition—and some of our Liberal and NDP members will remember that there was some resistance to the Independent Health Facilities Act when it was first implemented—I personally am an assessor with the college and I assess independent health facilities. What has come to light in that experience is that the Independent Health Facilities Act is actually a good thing. The quality assurance that that has brought into effect has really had an impact, and the actual process itself is doing what it's meant to do. It's a slow, tedious process because it's fairly involved. It's a fairly involved undertaking to assess 900 or so facilities in the province, but it's happening.

What we're finding is a high degree of cooperation, actually a higher-than-expected level of quality of service out there. The ones that are below par are being asked to close, and that's why we don't need the Minister of Health arbitrarily deciding on a closure. The way the bill is now written, if the quality is not up to par, it will be closed. That's the process, and we can all live with that.

To me, it seems to be a power related struggle. Pure and simple, that's what it seems like to me. If he could just arbitrarily say, "You close," what else is that then? Gaining power over our future.

The Chair: Thank you for your presentations, and for sharing your time, Ms Lee, with the doctors.

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LONDON INTERCOMMUNITY HEALTH CENTRE

The Chair: Next is the London InterCommunity Health Centre, represented by executive director Shanthi Radcliffe and community worker Ted Town.

Ms Shanthi Radcliffe: Mr Chairman, we have agreed to share our time with another presenter, Margaret Gregor.

Mr Ted Town: Good afternoon. I'm a community worker at the London InterCommunity Health Centre, and with me are community worker Sarah Merritt and our executive director, Shanthi Radcliffe.

The London InterCommunity Health Centre is a multidisciplinary agency serving what's known locally as London east. Since our formation in 1989 we've evolved into an organization with deep roots in the community and a client base of nearly 3,000 in our medical roster, with many more accessing our other programs.

The area we serve was once a vibrant working-class neighbourhood, although in recent decades it has undergone a downward economic spiral. At the same time, it's become home to a growing number of recent immigrants and refugees. Consequently, our client base tends to experience various barriers to health care. Our mandate is to provide sensitive and equitable health and social services to persons with complex needs who have difficulties accessing other sources for a variety of reasons. We're committed to providing comprehensive primary health care while concentrating on local and personal empowerment.

Our staff, which includes social workers, mental health workers, art therapists, full-time physicians and nurse

practitioners, are all paid by salary. This affords cost predictability and equitable care to all who come to us. We also offer various programs for immigrants and seniors as well as community gardens, English-as-a-second-language classes and an anonymous HIV testing clinic. Guiding us through all this is a philosophy of self-reliance. Our clients develop needs and issues related to the quality of life and health. We work with them to develop and provide services that meet those needs.

We're well aware of the current economic crisis facing the people of Ontario and we know that change is inevitable and necessary. We're concerned with the cycle of dependency that has developed over the years. We also know that there is a direct relation between wealth and health, that wealthier communities tend to be healthier communities. Personal and community empowerment can help break the cycle of poverty, dependence and illness.

The Mike Harris Forum on Bringing Common Sense to Health Care was released just over a year ago, December 2, 1994. One of the most striking aspects of this document was the unexpected common ground between the Progressive Conservative platform and the basic philosophy of the London InterCommunity Health Centre. Parts of this document could almost have been written by us. For example:

"Many of the access and affordability problems faced by our health care system could be resolved through a coordinated system of management, with health care professionals leading the way, working with government and incorporating community and consumer concerns.

"We believe that health care institutions and services should become more accountable to the people and their communities.

"Our commitment to a 'patient-based' system also demands the empowerment of health care consumers and their communities, and a greater emphasis on mutual responsibility between the health care system and the public."

And finally, the stated goal of the health care bill of rights was to "empower the consumers of the health care system with the rights to proper care and to participation in decisions regarding that care."

The thoroughness of the about-face manifested by Bill 26 is astounding. Considering that many election promises were indeed fulfilled by the Premier of Ontario soon after taking office, we're even more puzzled by the change in attitude towards health care.

Mike Harris said, "The community will be important in letting government know what's needed." This is a noble sentiment, but we're not here today because of the government's commitment to public input. We're here because a lot of other people fought for the very type of public consultation Mike Harris called for before the election.

When a newly elected government cuts social assistance payments before the Legislature even convenes on the ground that the financial situation is far too critical to allow time for public discussion; when a government creates a document so sweeping and unwieldy as to be intimidating to anyone hoping to examine it properly and then times the introduction and first reading of that document to coincide with the financial statement

occupying the time of the opposition and media; when a government only grudgingly allows public debate after a sit-in in the Legislature; when the time the government allows for those hearings is so short that routinely less than half those applying for presentation time can be accommodated; and when, after numerous criticisms and recommendations have been received, the government still insists the bill will be passed by the end of this month, serious concerns arise.

With what seems such a cavalier attitude toward public opinion, how can we put our faith in one person, in this case the Minister of Health, to determine what is in the public interest? How is this public interest defined? No doubt the minister, like many observers, has been struck by the sheer volume of participation these hearings have generated. How can we believe that one person has both the time to pore through that paperwork and the wisdom to sift through those recommendations, coming as they do from the entire range of socioeconomic strata, whether it's an Ottawa-born doctor concerned about being forced to practise in Smooth Rock Falls or a former psychiatric patient wondering how to pay for multiple prescriptions?

We're the first to recognize the current health care situation needs revamping, although we're less certain that money should be the driving force. The necessity and inevitability of change is not what concerns us most, however. What we're commenting on now is a bill that was never intended for public discussion and which by all accounts will become law within two weeks. How on earth can all the input from the public over the past month be given proper consideration and amendments to the bill be made in that length of time? If that isn't going to happen, then this exercise in democracy has been a hollow one. It's very disconcerting to think that these weeks of hearings have been moot, that they haven't told the government anything it didn't already know about determining what's in the public interest.

We're also concerned about what's not spelled out in the bill but what underscores it. We know much, but not everything, of what will happen if this bill is passed. We know when it will happen; the time frame is clearly spelled out. We know how it will happen, or at least how this bill provides for change to happen. It's the why that's causing us such concern.

We need to know why the government's access to private, personal medical information is being increased at the same time the public's access to government information is being decreased. We need to know why an amendment designed to combat health insurance fraud allows the Minister of Health to disclose this information to whomever the minister sees fit. We need to know why the government feels the need to enshrine its immunity from any sort of liability in the event of personal damage. We need to know why greater personal accountability is being demanded while government accountability is being eliminated. We need to know why the Minister of Health, in the name of fiscal savings, is allowing drug manufacturers to determine the price of their product, which the ministry will then pay.

The catch-all nature of the bill as it now stands makes an efficient study impossible. It's clear, however, that many of the fiscal savings it's intended to bring about

may not happen. If anything, costs could escalate down the line.

The community health centre offers a wide range of services and programs designed to be preventive and holistic. While significantly different from programs offered at other health centres and hospitals, they provide an indisputable example of cost-effectiveness in health care. From its inception, the community health centre has created its services around the themes of community consultation and appropriateness. What follows are some specific examples of the services we offer and how they could be affected if Bill 26 passes.

"For too long, the public has been a silent partner in important health care decisions and has had to defer to politicians and administrators to manage Ontario's health care system. Now, there is a strong demand for more of a community voice in those decisions."

Mike Harris said that in 1994, but it has been part of our philosophy since we started operating. It is our clients who identify what they need in their community as well as in their health centre, and there is an ongoing consultation among clients, staff and board members.

Like Mr Harris, we emphasize "preventive care which can help people avoid becoming ill in the first place." We take things a little further than most, however. We know that a wide range of factors beyond what's traditionally seen as health care in fact have a significant impact on health. Commonly referred to as "determinants of health," these factors include self-esteem, employment and language fluency, to name a few.

Many of the programs we offer differ widely from those offered by other health services, but their efficiency cannot be overlooked. As an example, the SAFE—Self Abuse Finally Ends—Canada program offers art and group therapy for women with a history of self-destructive or abusive behaviour, many of whom were frequent users of more traditional services. To give just one example, one client spent 76 days in hospital in a single year, with related social agency and police involvement at phenomenal cost to the system. One year later, after completing the SAFE program, the same person spent a total of two days in hospital, without using any ambulance, police or agency costs.

More than 300 people have been involved in SAFE since its inception five years ago and 25% of them have had no need to use other services.

To use another example, reiterated many times with slight variance in detail, another woman who was a sole-support parent with two children received \$17,000 annually through family benefits allowance. Through the various programs we offer—helping women to overcome language barriers or low education levels, teaching them self-reliance and job skills—she found a \$31,000-a-year job. Various levels of government are now receiving tax payments from this woman where before they paid social assistance benefits.

Our volunteer board is reflective of the many facets of the health centre, and each of our some 20 programs is directed by its own advisory committee of community members. They're all linked in an efficiently functioning whole by their belief in the centre's philosophy. We have, therefore, serious concerns about provisions in the bill

which undermine the structure of autonomy and individuality, this gearing of services to community requests. Amendments to the Public Hospitals Act could effectively hobble local boards of directors and their relationships to the communities they serve. Boards could find themselves unable to make decisions and be confident of carrying them out. The Minister of Health would have the power to exclude members of the community from any real decision-making in the operation of the centre. This can only result in the disappearance of the spirit of volunteerism. At our health centre alone, we estimate some 30,000 volunteer hours annually. Clearly, we have a lot at stake.

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This goes against one of the most fundamental principles of our health centre, namely, that participation is critical to health. Powerlessness leads to dependency. Dependency is unhealthy. We know we're not alone in this sentiment; part of the rationale behind the government's recent cuts to social programs was to wean people from the cycle of dependency.

Once again, we have to wonder what became of the Progressive Conservative sentiments of not so long ago that, "True consultation only occurs when government not only listens to the people but hears what they have to say and responds to their concerns with action."

We return to the phrase "in the public interest" and the Health minister's determination of it. We can only hope that the Health minister, who no doubt has been watching these hearings, will recognize that a significant portion of Bill 26 is not in the public interest.

We believe that the concept of public interest is a dynamic one and that what may be seen as a benefit to one group is often detrimental to another. We are very concerned, therefore, that any definition of "public interest" take into account the huge diversity of Ontario's population: it must consider the influences of language, age, gender, physical abilities, economic status, culture, ethnic makeup etc; and that it be arrived at with due process and appropriate consultation.

We have serious concerns about sections of Bill 26 which "would give the minister power to collect, use and disclose personal information for specified purposes and to enter into agreements for the exchange of personal information for specified purposes. The director would be allowed to require licensees to provide information for specified purposes."

These are dangerous waters. Health insurance inspectors and inspectors from the College of Physicians and Surgeons already have access to files when reviewing cases of health insurance fraud or medical misconduct. Those officials, from arm's-length bodies, are sworn to secrecy. The Health minister disclosing information to as-yet-unspecified parties, with no provision for appeal, is another matter altogether.

If patients cannot be guaranteed confidentiality, they are less likely to discuss their situation. In effect, each visit to a doctor would imply tacit consent to the distribution of their medical files. It doesn't matter if this fear is unfounded; it's the perception that's all-important. Patients with heart conditions, for example, or diabetes, may be unwilling to have their names end up in the files of a drug manufacturing company.

We're not suggesting a free-for-all with confidential files is in the offing, but the provisions in the bill are simply too vague. Again, even with official assurances that these powers will not be abused, with the absence of safeguards, that fear is there. Physicians can't treat patients who won't say where it hurts. Medical costs can only increase if the treatment is delayed. There is no fiscal saving to be found here, let alone any hint of the sentiments we heard in the health care bill of rights, which talked of the "right to treatment free of discrimination and which recognizes one's privacy, dignity and individuality."

The health centre also houses Options Clinic, an anonymous HIV testing site. More than 4,300 people have used the clinic's services since it opened in 1992.

Anonymous clinics were established to remove one of the most significant barriers to HIV testing for many people: the fear of identification, of being reported to public health boards. Anonymous sites are allowed to operate on condition they provide appropriate HIV education and counselling. Options Clinic staff offer prevention strategies and refer clients to appropriate medical and support services when needed.

Data from the AIDS bureau of the Ministry of Health show that more people test anonymously than through their family doctors. The data also show that because of the counselling that accompanies anonymous testing, people are less likely to become infected. Finally, HIV-positive people who are aware of their status generally change their behaviour and are less likely to infect others.

When early detection and treatment of HIV infection is compared with the estimated \$100,000 required to treat a patient with full-blown AIDS, the fiscal savings attributed to anonymous clinics cannot be ignored. Furthermore, Ministry of Health figures put the cost of anonymous testing at \$44, compared with \$100 for a test done by a physician.

A perceived risk to confidentiality, however, is all it takes to keep people away. Time and again, Options Clinic staff assure people making appointments by telephone that the service is 100% anonymous. This concern is particularly prevalent whenever there is any talk of identifying HIV-positive people, whether by local health boards or blood donor clinics.

The perception of untouchability has to be maintained at all times. We cannot support any new access to records that might make even one person think twice about being tested. As surely as we're all sitting here today, this bill, with its provisions concerning access to and disclosure of personal medical records, will keep people away from Options and other anonymous testing clinics. The potential for horrific consequences, both in financial and human terms, is huge.

We have grave concerns as well concerning amendments which would "prevent persons from claiming compensation against the crown, the director or the minister for damages resulting from specified actions."

This immunity is astounding. We are unable to support a clause such as this without further explanation. Where are the data to support the assumption of so much mismanagement and fraud in our system that would warrant the unilateral removal of such basic rights as

those of confidentiality and appeal? Is a wave of litigation foreseen on the horizon with the passage of this bill? We don't believe it's asking too much to want to know why this immunity is being enshrined in legislation, and, it's safe to say, neither would anybody considering a trip to the doctor. It's ironic that at a time when access to information is getting more difficult, one's own, most personal information is seen to be up for grabs.

One of the cornerstones of the Common Sense Revolution was "no new user fees," and if Bill 26 is passed as it stands, the Ontario Drug Benefit Act will no longer pay the maximum dispensing fee. The proposed dispensing fees can have wide-ranging ramifications for some people. A \$2 charge means one thing to the person who needs only the occasional prescription filled; it means something else entirely to the person who may have several per day. In many cases, the people who need various medications the most are those who are on social assistance programs. Some of them are poor because they're sick, and some of them are sick because they're poor. But either way, the proposed copayments following on the heels of the welfare cuts will mean an overwhelming situation for many people. People may be forced to choose between paying for food and paying for medication. For those whose prescriptions must be taken with food, something else will have to be omitted. Some people may decide on their own which prescriptions they won't get filled this time.

Anyone who has had children or siblings knows that when one gets sick, others do as well. Often three or four people in the household will require the same medication, but doctors are not allowed to draw up one prescription for more than one person. Again, prescription fees could be prohibitively expensive in some cases, and the potential for serious health care costs further down the road cannot be ignored.

These situations contrast with Mr Harris's statement that: "A key way to contain health care costs and effectively manage resources is to invest in preventive health care. The best health care system is one that promotes wellness and prevents illness."

As Ms Lankin touched on about 30 minutes ago, we're unclear about the deregulation, whether a dispensing fee in fact is a user fee or a copayment. If it's the latter, will pharmacists be allowed to waive this fee? If they are, will it not work together with the proposed deregulation of drug prices to the advantage of retail giants who can afford loss-leaders and drive small pharmacies, such as those that are in our neighbourhood, out of business?

It's probably safe to say that if prescriptions and medications were easy to figure out, there wouldn't be a five-year program for pharmacists, so it's difficult to imagine how the Ministry of Health will be able to sort out what pharmacists and doctors are often at odds over: What constitutes an effective treatment? Medications still work independently of legislation, and due to what's known as the bio-availability of a drug, some people suffer allergic reactions to a drug which technically is designed to cure what ails them. If a similar but no longer interchangeable drug is on the pharmacist's shelf, it may not be available to that person due to the cost. So there's a dilemma here: A person can take the paid-for

drug and get sicker, or that person can pay for the drug that works and get poorer. Either way, there's little chance of economic recovery here—not at the individual level or at the governmental level.

In summary, the voluminous nature of Bill 26, with barely two weeks in which to secure the necessary documentation and develop this response, allows us only the opportunity to bring forward our key concerns. Encompassing all the items we've noted—and others we've not, however—is our deep concern that the acknowledged fiscal imperatives are driving us towards a structure of health care that is both disjointed and ultimately destructive. The principles of the Canada Health Act have provided a vision of health care based on equity that every survey has shown to be highly valued by Canadians. Indeed, some even define their national identity by it. By what values is Bill 26 guided besides that of deficit reduction? When the headlong rush to cost-cutting is over, what will the delivery system look like? As institutional health care downsizes in the name of community-based care, which incidentally is also being decimated, what becomes of the patient who is faced with a six-month waiting list for needed service at every level?

Our recommendations, to sum up, are:

That Bill 26 be divided up into individual packages, each specific to its own particular area of concern. These sections can then be more accurately studied by those people they'll affect.

That the time frame in which the bill is to be studied be extended to allow a more accurate measure of the public interest.

That any consideration of public interest take into account the huge diversity of Ontario's population, and include appropriate consultation.

That Bill 26 enshrine provisions to ensure that the public is a key player in determining local health care priorities, in keeping with the spirit of the Common Sense Revolution.

That provisions to retain the autonomy of local boards be included in Bill 26.

That any amendments to the Ministry of Health Act ensure that patient confidentiality will be breached.

That the provisions prohibiting the public from seeking compensation for damages be clarified or deleted as they stand.

That the amendments to the Independent Health Facilities Act be removed.

That the provisions in the bill introducing copayments for prescription drugs be deleted.

That the provisions allowing the deregulation of drug prices be deleted.

Finally, that the provisions of Bill 26 respecting health care services be amended to ensure that the health care goals expressed in the document Bringing Common Sense to Health Care are not nullified. We thank you for your time.

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Mrs Margaret Gregor: I would like to express my appreciation to these people for sharing their time at this hearing.

Good afternoon. My name is Margaret Gregor. I'm the elected executive vice-president of the Brant-Haldimand

Liberal Association and I'm also active as a director on the board of the Oxford Provincial Liberal Association. However, I am speaking today as a non-partisan citizen concerned with the democratic civil rights and liberties of Canadian Ontario citizens. I'm also concerned about the rights and privileges of physicians and medical personnel who serve and care for us.

As the member of a family whose father served in the First World War and sent four sons to fight for cherished freedoms in the Second World War, I am very concerned about the powers that this government is proposing to take over in Bill 26. The more I study this bill, the more concerned I am that the arbitrary control and authority placed in the minister's powers are to be allowed to pass unquestioned. Surely if our individual rights and freedoms were fought for and bought at such human sacrifice, it behooves us to protect and defend these rights now.

Regarding the health issues, and this has been spoken of, confidentiality of information between doctor and patient is not only a privilege but a right that cannot and should not be denied.

Individual choice of physicians and surgeons to practise where they choose is also a democratic right and privilege as long as they are providing legitimate service and care. Decisions regarding adequate servicing of doctors in all areas in Ontario should be a matter decided by the government in partnership with the Ontario Medical Association.

Phrases such as "without prior notice" and "imposing, ending or extending moratoriums" regarding control of numbers of eligible doctors in certain areas have possibilities of extreme power over physicians' lives and decisions, both in their family lives and practices.

I have strong objections also to schedule H, page 112, subsection (1.2), which proposes creation of "different classes of persons" with "different entitlements...relating to each class," establishing "different requirements, conditions or restrictions on or relating to each class". Such statements as these are surely in strong opposition to our Charter of Human Rights and Freedoms, and I am surprised they have not been spoken of more fully in these hearings.

In many cases, as I read this Bill 26, I note that there are few, if any, opportunities to dispute or challenge a person's rights with regard to this bill.

Schedule I, page 118, subsection 1(4) says, "If a right or obligation is designated under this act, a decision, ruling, award or order made in a proceeding relating to a dispute about the right or obligation shall be of no force or effect." So no challenge is possible.

Mr Chairman, ladies and gentlemen of this government committee, I not only suggest, but appeal to you that this Bill 26 is seriously flawed. This act should be completely revamped to live up to our rights and privileges in a democratic society.

I might add that someone, Terence Young, suggested to me that sundowning was suggested, as some of these rights might come into force and then be moved away. I don't believe that privileges that are allowed under this type of bill are going to disappear. It's something like the GST; once you've got it, it's forever with us.

Sources referred to in Bill 26: I would like to refer to these in order to prove that I've spoken honestly.

Part I, Health Insurance Act. Subsection 2(4.1) of the act, page 91, "The minister may...collect, use and disclose personal information concerning insured services provided by physicians, practitioners or health facilities.

"(4.2) Information may be collected directly"—and this is the phrase I dislike—"or indirectly under subsection (4.1)."

What does this refer to? It could be almost anything.

Schedule H, page 103, subsection 29.3(1), "The minister may, by regulation, fix or vary the number of physicians...who may become eligible physicians in an area after the date on which this section comes into force. The minister may do so"—underlined—"without prior notice.

"(2) The Minister may, by regulation, determine from time to time the areas of Ontario that are oversupplied with physicians....

"(6) The minister may impose, end or extend a moratorium"—preventing more eligible physicians in an area, underlined—"without prior notice."

Section 29.4:

"(7) An exemption may be made....

"(8) The minister may designate a person to exercise his or her powers" to decide such exemptions.

I am very much against one person deciding an exemption for such broad powers.

Schedule H, page 109, subsection 40.1(1), "An inspector has the following powers....

"5. To inspect and receive information from health records or from notes, charts and other material relating to patient care and to reproduce and retain copies of them.

"7. To remove material described in paragraph 5...for the purpose of copying it....The material must be promptly returned to the person apparently in charge"—I certainly don't like that quote—"of the premises from which the material is removed." It could almost be the caretaker.

Schedule H, page 112, and this is my own statement: I have strong objections to this section and I am very much surprised that this has not been debated more. This is put under "Classes" and certainly is against any democratic principles I have understood.

"(1.2) A regulation may create different classes of persons...and may establish different entitlements for or relating to each class or impose different requirements, conditions or restrictions on or relating to each class."

"(3.1) A regulation may exempt a class of persons or facilities from the application of a specified provision of the act or regulations."

In other words, those to whom they wish to apply this act, they may do so, and if they wish not to apply this act, then they don't. I don't see the justice in that.

Schedule I, page 118, section 1(4), and this is underlined:

"If a right or obligation is designated under this act, a decision, ruling, award or order made in a proceeding relating to a dispute about the right or obligation shall be of no force or effect."

In other words, you have no appeal to the courts.

To speak in summary, I'd like to read a letter written to the Brantford Expositor by Dr Robert Eddy. I have his permission to read this letter. I feel that it is a concise way of finalizing my submission.

"Is This What the Citizens Want?"

"One newspaper used to have an important logo at the top of its editorial page—something to the effect of 'not proposing or submitting to arbitrary measures.' I always admired that quotation.

"Currently, I and my profession"—and this is Dr Robert Eddy speaking—"are being subjected to arbitrary measures. I am writing this letter as a citizen, protesting not just on behalf of my profession, but on behalf of all citizens of this model democracy of ours.

"As thinking people, doctors are aware of the country's and the province's economic situation, and aware that we must share the financial burden of its correction. We have done so and continue to do so.

"My protest is not an economic one. The arbitrary measures to which I am protesting are the following in Bill 26, the" ominous bill—"omnibus bill." I beg your pardon. "Omnibus" is probably a good word, right?

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"The limitation of doctors' licences granted in the province, without the advice of the Ontario Medical Association.

"The restriction of geographical areas in which a doctor may practise, without the advice of the Ontario Medical Association.

"Decisions about which medical services will be provided in which facility, without the advice of the Ontario Medical Association.

"The ability of a government official to seize medical health records of patients from doctors' offices without a warrant.

"The government arbitrarily deciding which medical procedures, services and tests will be covered in the health plan, without the advice of the Ontario Medical Association.

"The government arbitrarily deciding which medical services are necessary, without the advice of the Ontario Medical Association.

"The government's arbitrary termination of existing agreements with the Ontario Medical Association.

"My profession is willing to handle the problems of distribution of Ontario physicians, the problem of the luxury utilization of resources, and the other problems which involve the profession. We would like to do it in a partnership way with the government so that our expertise might be available.

"But instead we are being told to submit to arbitrary measures.

"The character of your province's medical profession may be permanently changed by this legislation."

I would like to add that I feel that it will, and probably already has, by the exodus of so many physicians already from our group. Is this what we as citizens want?

The Chair: Thank you very much for your presentation. I've been quite generous to allow you to at least read the letter at the end, as far as time goes. We appreciate your being here.

PERSONS UNITED FOR SELF HELP LONDON ACTION LEAGUE OF PHYSICALLY HANDICAPPED ADULTS

The Chair: Our next group represents PUSH, Persons United for Self-Help, Bonnie Quesnel. Good afternoon and welcome to our committee.

Ms Bonnie Quesnel: Thank you, Mr Chairman and members of the committee. I'd like you to note first that I'm sharing part of the time with another group, called ALPHA, the Action League of Physically Handicapped Adults. It's another organization that is involved with people with disabilities. Let me begin.

Persons United for Self-Help is an organization which has long been committed to working for the advancement, integration and achievements of people with disabilities. We, better than most, understand the complications and difficulties which are faced by people caught up in a health system that has lost its humanity and accountability. Ontario as a whole has not yet been exposed to the second-class and bureaucratic health care that we who have disabilities know so well. The general public does not yet comprehend the "least for the most and the best for the rest" type of service provision. We do; we have known it for some time.

PUSH has already begun to see a class structure infiltrating our health care system. This is partially attributable to previous cuts and anticipation of the government's November budget. It is openly reflected in the marginal availability of timely, accessible service. It is also reflected in the insistent demand for "Do not resuscitate" notations on our files prior to taking our temperatures. Several PUSH members have recently sought medical support for correctable conditions; for example, hernia, bronchitis and bowel obstruction. They were all asked for this DNR designation while receiving treatment. Would you able-bodied, working individuals have been asked for this? We think not. Assumptions about your value and merit have been processed and it is believed that your life is worth living, saving and investing health dollars into.

The new human valuations and devaluations that will transpire within the sacred white halls are awesomely fearful. What happens when the new experts, those who decide who will get the survival care versus who is made "politely" comfortable, are no longer accountable to anyone? Change can be made by a few but will impact upon many. This legislation would deny an alternative prospect—an avenue of appeal—to everyone. Is an election every five years going to be our only recourse? Is this protection enough for those who are vulnerable and lack the money and/or machinery to prevail?

How often have we heard the words "quality of life" applied to a person who dared to get old or a young adult born with one or more disabilities? Their health needs shrink under a magnifying glass of some anonymous expert reciting positions on quality of life. Able-bodied and employed served first; all others to the rear. This is the essence of triage, omnibus style.

People with disabilities have experienced being marginalized and ignored by powerful decision-makers for many years. We have been victimized before by those

who told us to trust them, that they knew what we needed. What you propose now is worse. We have the insights necessary to warn you of the problems in this Bill 26.

History reveals that in times of fiscal restraint it is those with the least perceived power who suffer most from the scapegoating devices. It reminds one of being on a whitewater raft ride where everyone ultimately falls into the void. Three have lifejackets and survive to tell others of their awful peril. The others could not afford, or were deemed unworthy of receiving, lifejackets—and they do not come back. No one will ever hear their tales of true horror. This is what the current omnibus legislation will achieve in our health care system. This bill increases vulnerability and hostility towards people with disabilities—those without lifejackets. It will encourage the health care system to identify people with disabilities as an expensive burden, a stereotype used extensively in the past. It simplifies the route for politicians and bureaucrats—some of them with the lifejackets—to forget about our humanness and our contributions, to see our rights as vexatious irritations, just like the wild white water. This easily adopted perspective will lead to the loss of our vital rights.

Let us take a look at some specific items outlined in the bill.

Schedule A, disclosure of salaries: This is only reasonable if it applies to the profit sector as well as the non-profit sector. This becomes an even more important consideration when one hopes that more for-profit services are getting involved in health services. It is impossible to compare any kind of service efficiencies when only one segment of data is available. Certainly long-range planning demands maximum data collection from all involved sources.

Schedule F: Will the minister's and his government's definition of "public interest" include all Ontarians? In the name of proper management of the health care system, will people with disabilities and others from the lower levels of your hierarchy be institutionalized, warehoused or denied service? If this is not your intent, then provide us with avenues of appeal and redress, with specific guarantees. Don't ask us for blind trust, knowing that our experience has shown the error of such action. Blind trust is something we have run out of. We need commitments and we need them now.

We would also like to know just what is an independent health facility. Will the unknown definition of this section lead to a two-tiered health care system as exists in the United States? We know that the American health system is not cheaper or accessible. In fact, it's been proven to be an expensive disaster.

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We also know who suffers most in the American system—the disabled, the elderly and the poor. Why would we try to replicate failure? Caution lights are flashing throughout our community. Our raft is about ready to overturn and we are the people without lifejackets. Any change of this magnitude should be studied and reviewed more carefully before implementation.

Schedule G: We believe that deregulation of drug prices has nothing to do with deficit reduction. Whom

does it serve? In whose public interest is it being put forth? Why is it here? This concept is truly a violation of those who struggle daily to make ends meet. It dictates that there will be one standard for the government and another, more costly standard for the public. To some, such will have no impact. To others it becomes a life-and-death issue. Again we ask, in whose public interest is it?

Further, the copayment user fees for prescriptions will directly contradict promises made to Ontario prior to election day. These fees cannot be afforded by people with disabilities, seniors or the poor. Is this the intent of this government?

Schedule H: Fees, fees and copayments. Nothing is to be deemed necessary, therefore nothing must be paid for. No anaesthetic to numb surgical pain, no morphine to dull cancer's agony, nothing. The minister will decide who gets what, how much and when. Such discretionary power raises fathoms of ethical and moral obligations and questions.

Perhaps this approach would not be so frightening if we people with disabilities knew that our needs were being included in the plan. However, we're like Cinderella watching our stepsisters going off to the dance, knowing that we are only part of the cleanup crew, our portion consistently being leftovers. We have little reason to think that this time will be different. We cannot face another bout of white water without the safety of a lifejacket of commitment from the provincial planners such as yourselves.

Other: By amending three separate pieces of legislation, Bill 26 shreds away our right to privacy and dignity. In days gone by, when citizens shared information and later found it was abused and misused, there were avenues of remedy to access. Omnibus dismisses our security rights flatly. Absolute access to all of an individual's records for arbitrary reasons is an endorsement which decries logic. No government could possibly want to invade its citizenry so fully. Surely this is not the KGB.

With information technology progressing at warp speed and technical experts scrambling to safeguard their data, we in Ontario are being asked to yield all. We are to go without the lifejackets, drifting while others invade and violate our personal information, deciding when or if we can get back into the boat. This is wrong. No explanation will justify such abuse.

My conclusion is this: We know that good leadership weighs risk against outcomes before committing to a system overhaul. This is a difficult position when one recalls that the legislation we are here to address is supposed to be a housekeeping document, not a reform document.

We know that it's difficult to anticipate all of the impact implications of this omnibus planned actions. However, it is foolish to pursue action when gaping flaws are already apparent. This is no time for political posturing. This is not the kind of bill that demonstrates conservative progress. We need the reflective concern and common sense that you assured us would be ours. Anything less will not be good enough, and I thank you for your time.

Dr Shirley Van Hoof: Patti's going to say a word.

Ms Quesnel: Okay. This is Patti. She's the chair of ALPHA.

Ms Patti Doolittle: Hi. Good afternoon. I'm the chairperson for ALPHA and we're a subcommittee of the southwestern March of Dimes.

First of all, I'd like to thank you for southwestern for allowing us to have this presentation time during your speaking time. Also, thank you to Ontario March of Dimes for helping us prepare both written and oral presentations.

The background of ALPHA: The Action League of Physically Handicapped Adults has been fighting over the past 25 years. We have worked to improve the quality of life for persons with disabilities. This includes all aspects of life that affect all people. After all, we are people too with extra challenges. ALPHA believes that Bill 26 threatens the right to live with dignity for all vulnerable citizens, including children, the poor, the unemployed and the sick and/or disabled.

Now I'd like to turn over the presentation to Dr Shirley Van Hoof.

Dr Van Hoof: Thank you very much, Patti. I'd like to present an overview.

ALPHA finds few redeeming features in Bill 26 and would prefer to have it withdrawn. The next best thing is to have the bill presented in pieces, with substantial consultation with the affected parties on each section. A full assessment of the effects of the proposed changes must be undertaken before any part of this bill is passed. The rush to pass this legislation is scary.

Themes that pervade the document include (1) Increased powers given to a single person and taken from boards or other groups of people; (2) immunity; and (3) lack of appeal process.

We need more than one set of thought processes to tackle complex issues, as all of us have blind spots or soft spots that may unduly influence decisions. Boards were developed over time as a cooperative way to make decisions so that the biggest, strongest or most financially endowed do not infringe on the needs and rights of other citizens. Any time one person can close facilities and open others, withdraw services and cover others, corruption is just waiting to happen. To hand absolute power to one person is inviting an abuse of that power and should not be done.

Immunity for harm done to people or property is ludicrous. If in Bill 26 powers are being used "in the public interest," as stated so many times in this bill, then why the emphasis on immunity from repercussions when Bill 26 is implemented? In recent times, persons in power have been held accountable for their actions. This government will be held accountable for the impact of its legislation. Ferdinand Marcos of the Phillipines and Nicolai Ceausescu of Romania were both held accountable. Unfortunately, families that give up a child to the children's aid society or place a loved one with a disability in an institution because their resources have been decreased by Bill 26 are changed forever.

Lack of an appeal process gives decision-makers absolute power, which must be avoided. I'd like to quote from a letter from Lord Acton to Bishop Mandell Creigh-

ton, April 5, 1887, which said, "Power tends to corrupt and absolute power tends to corrupt absolutely." I think that's very relevant here.

Even the best and most thought-out legislation in the past has been found to have areas which need revision that could not have been anticipated until actually put into practice. To eliminate an appeal process would totally eliminate this valuable feedback and practical working experience.

Under discussion since this government took office in June 1995, persons with disabilities have been hurt in many ways, and Bill 26 will increase the disadvantages to which we are exposed.

Under health, the present status: Decreased funding has increased waiting times for doctors' appointments, decreased fees to laboratories for home services at a time when people are remaining at home when quite ill, questions by health professionals to persons with disabilities which are inappropriate, and you've already heard the DNR example. Some persons with disabilities are being denied treatment for a broken limb, pneumonia and other ailments. Some physicians today refuse to accept patients with certain conditions, MS, for example. In smaller communities this may effectively mean a person with a disability does not have access to routine medical care. Such service cuts are discriminatory and cannot be tolerated.

Given these present realities, this proposed legislation would further marginalize persons with disabilities.

Under transportation: A 6.2% decrease in funding began in 1995 and is still in effect in 1996 and 1997. Bill 26 will give municipalities further powers to alter funding, implement user fees and change whatever they wish without consultation.

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The critical issues. Under health:

1. A universal public health care system is crucial. A two-tier system is not acceptable.

2. With the addition of multiple copayments, the poor must choose between food, rent, medicine and assistive devices. Exceptionally high costs for basic medical and essential living expenses for persons with a disability is readily substantiated. To even consider copayments for prescribed medications for persons with disabilities would clearly be intolerable.

3. Using age as a criteria for health care is discriminatory. Not only the old and young but certain categories could be targeted.

4. Allowing the "manager" and not the person's physicians to decide what is "medically or therapeutically"—again not defined—necessary is unacceptable. This would seriously jeopardize the doctor-patient relationship and not utilize the knowledge and experience of the physician.

5. Coverage of treatments can be changed even retrospectively. Life-saving procedures may be delayed while clarification of coverage or family guarantee of payment is received. This is also totally unacceptable.

6. Cost and whether doctors will be paid will now be part of the decision-making process, which will result in the Americanization of our health care system.

7. If drug costs are unregulated, costs will increase to consumers. We've heard today that they may decrease after five years, but in the meantime what do we do? We pay through the nose. This does not address savings and restructuring as Bill 26 purports to accomplish.

8. The confidentiality of patient records under this legislation is not protected. This is considered sacrosanct and the legislation must be amended to guarantee such confidentiality.

9. Any limitations which will govern how and where physicians may practise in the future, as noted in section 29.4 will again further reduce the opportunity and availability of medical care for persons with disabilities in many communities.

Other issues:

10. Sweeping new powers to municipalities with no need to consult the public will hurt many citizens, especially the disadvantaged:

Transportation: I talked about the 6.2% cut, which remains until January 1998.

Education: Reductions in funding to adult and post-secondary education and the power to decrease or eliminate junior kindergarten and kindergarten.

User fees: A regressive form of taxation for necessities such as garbage collection and recreation facilities.

11. The amendments to pay equity legislation is a step backwards for women, combined with decreased support for child care, battered women's shelters, homes for unwed mothers and the repeal of the Employment Equity Act. If women are affected, women with disabilities are further penalized.

12. Decreased environmental protection standards, whether at mine sites or for garbage incinerators, are unacceptable.

In summation: Bill 26 encourages the attitude that those who have bear no social or economic responsibility for the other citizens of this great province. Citizens have repeatedly supported funding for education, health care, the poor and the disabled and yet Bill 26 potentially decimates all of these. To repeat the opening comments, ALPHA beseeches the provincial government to repeal Bill 26 or seek further consultation on the broad range of sweeping powers this legislation represents.

Thank you for the opportunity to present our concerns and we await the results of these hearings.

Mr Steve Balcom: I'll be addressing the questions.

The Chair: Oh, we've got one more person to talk, have we?

Mr Balcom: No. I'm going to be addressing the questions.

The Chair: Okay. Beginning with the government. Sorry, Mrs Johns. I got a little confused there.

Mrs Helen Johns (Huron): That's okay. Thank you very much for your presentation, all of you. It's nice to see you again, doctor, and it's always interesting what you have to say. In a short time, I don't exactly have a question. I just wanted to say that I recognize a couple of things that you've said.

I, as a person in Ontario, feel that I've been without a lifejacket also for the last few years as debt has increased. We have been unable to get it under control and it's

wreaked havoc with the debt and the amount of money we have for all social programs, so I understand that.

I recognize that you said you feel your plight has been getting consistently worse for a number of years and it just continues to be worse.

I want to just comment about the age factor. I know this is a technicality when you have so many important things that you say in the bill, but since I have no time—the age factor was in the previous bill and it's in this bill also, so it's not something new coming out with this age differential. If you'd like to make any comments on that. Do I have any time, Jack?

The Chair: No, you don't.

Mrs Johns: Sorry.

Mrs Pupatello: If the group doesn't mind, I'd like to address just initially the comments to the Conservative member.

Mrs Johns, really, all of us are surprised. That you would even consider comparing the lifejacket of the Ontario debt on your shoulders to what some groups in Ontario suffer from is unbearable and unacceptable to come from government, and you're going to have to withdraw those remarks. You cannot for a moment compare that you personally have had any suffering, given where you come from, in comparison to what some groups have in terms of disadvantages in Ontario.

Mrs Johns: We can't afford the health care that these people need because people have overspent in previous governments.

The Chair: Mrs Pupatello has the floor.

Mrs Pupatello: The reality is that the bill that is being presented today is simply going to make it worse for many people in Ontario. That is completely unacceptable, and I submit that most people in Ontario agree with me on this. That is unbelievable. Perhaps you'd like to make a comment.

Mr Balcom: I am sitting here shaking my head personally in disgust—mostly in disgust, mostly in bewilderment at the politicized nature of the issue that you're dealing with. We live it every day, 365 days a year. And you're right, I am greatly insulted, because there's no comparison. That's about all I have to say.

The Chair: Thank you very much. Ms Lankin.

Mrs Caplan: Apologize.

Mrs Pupatello: You should apologize. You should be ashamed of yourself.

Ms Lankin: I want to specifically address one thing Mrs Johns said on a technical nature. She did mention that the issue with respect to discrimination of services based on age was in the old act, and I sort of sigh with weariness at this because we've been over it so many times.

She knows well that in the old act that was provided for in a context of regulation powers that was covered by a clause that said all of this had to be done in accordance with the Canada Health Act, which meant, for example, things like breast cancer screening programs for women over age 55. There are some things that have been prescribed by age but in that context.

This government has taken that age provision, moved it out, put it in another part of the act which is not under the protection of that clause saying that the government

has to do it in accordance with the Canada Health Act. If that's not what they intend, they'll have to amend that, but it's not correct to keep saying to people it's the same as it was before.

I'd like to leave the last few seconds to you. Any comments you would like to make and message you would like to give to this government with respect to this bill?

Dr Van Hoof: Repeal the bill. Like I just said, withdraw it, because there are no redeeming features in this bill for us. And to say that you have to cut costs at our expense and you're sorry, I don't believe you. As you get your Porsche out to drive, I don't feel sorry for you. You cannot reduce the deficit on the backs of the poor and the disabled. That is not the Canadian way.

The Chair: Thank you very much. We do appreciate your being here this afternoon and your presentation.

We're going to take a three-minute recess.

The committee recessed from 1558 to 1605.

The Chair: Okay. The three minutes are up. We're back in business.

JAMES ROURKE

The Chair: Our next presenter is Dr James Rourke, who is a rural family physician. Welcome, doctor, to our committee.

Dr James Rourke: Thank you very much. I guess everyone's here who's coming.

Just as a brief note of introduction, I'm a rural family doctor from Goderich, Ontario, and I've had the joy of practising in rural practice for the last 16 years there. I've also been involved in teaching students and residents in our practice and residents for the last approximately seven years. I've been involved in the educational end of things. I've been involved in doing some research on the rural practice both in Ontario, Canada, and around the world, and involved in various policy-producing groups and chairing several of those for the Ministry of Health, the Ontario Medical Association and the Ontario Hospital Association.

I also had the privilege last year to travel to Australia for six months and be heavily involved in their rural practice difficulties and their approach to rural practice, and I've been involved with the World Organization of Family Doctors in preparing a policy statement for them on training doctors for rural practice.

So that's the perspective I'm trying to bring to this, to point out the need for rural health care and the need for some action. I understand that's part of the reason why this bill has been developed, to try to address those needs. I'm not going to comment on whether this bill is the best way to address those needs, but I want to highlight what the needs of rural practice are.

What I've done for the committee members is prepared a brief that I hope you have in front of you. Do you have a brief in front of you?

Mrs Pupatello: We're getting more copies made of the presentation.

Dr Rourke: Just to start by highlighting the need to address rural health care, I would tell you that 2,497,000 people live in rural Ontario as defined by Statistics

Canada's definition of "rural" as up to 10,000 people. That's 24.8% of the Ontario population.

The health care for that 24.8% of the Ontario population is under jeopardy now, it is getting worse and not better, and it's time for some action. Basic medical care needs for the rural population of Ontario include local access to a family doctor, access to emergency medical care within a reasonable time and distance, safe obstetrical care as close to home as possible, special aboriginal and first nations health care needs, psychiatry services, access to other general specialty services such as internal medicine, access to specialized care by outreach clinics, and access to secondary and tertiary care centre resources. Each of these is under serious threat at this point in time, and there has been little action done to address those over the last 10 years.

I put in some definitions of rural practice so that people can understand what rural medical practice is and how it differs from city practice. There's a vast difference. Some of those differences include the large population-to-doctor ratio and the fact that family doctors in rural areas are called upon to do many things that in urban areas family doctors don't do, but that are done by specialists. Those include hospital care of all sorts, including a lot of obstetrical care, emergency care, doing anaesthetics, minor surgery and sometimes major surgery.

There's limited and distant specialist backup and a very small number of rural specialists. There's difficulty securing relief for holidays or education. I also want you to know that recruitment retention, of course, is more difficult the further away you go from the larger urban centres and that a lot of the recruitment retention difficulties are part of spousal and personal and children concerns as opposed to professional concerns.

I'm going to talk briefly about our progress to date and then I'm going to talk about what needs to be done and the need for the government to act on this at this point.

Overall, progress has been poor. There is a worsening situation for the provision of safe obstetrical services in our province. That's gotten worse over the last seven years. The problems of rural health care have now reached a crisis proportion, not only for rural emergency services but most rural health services, as indicated by the independent Scott report. I'm sure you're all familiar with the Scott report, but one of the good things about the Scott report was that it wasn't done by a rural doctor, it wasn't done by a politician, it wasn't done by a rural hospital administrator, and Scott called the shots the way they were. I think it's received widespread acceptance as this reflects the reality of today's rural practice crisis.

Just to draw your attention to the crisis, let's look at the marked urban-rural maldistribution of doctors. I'm going to talk about family doctors as if they're not non-specialists, because the data we have are for non-specialists. This is 1994 data from the Ontario physician human resource data centre.

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For the province, there's one non-specialist for every 1,100 people. In Metro Toronto there's one for every 836 people. In London it's one for every 983 people. But if you go up to the more rural areas, even just up the road

where I live in Huron county, in Bruce county—that's not very far away—it's one to 1,400 people.

Let me tell you, it should be the exact opposite, because I'm only a 60% family doctor, like most of my colleagues. Some 40% of my time is spent doing hospital-based medicine. So compared to the office-based family doctor in the city, I can only do 60% of the office-based time that they can provide. So the ratio should be different. There should be more of us per population in the rural areas instead of less.

Let's just flip over to emergency care for a second. I'm not going to spend a lot of time on that because Scott has addressed that, but I will indicate that the current government has made the first initiative in addressing this rural emergency care crisis that's been with us for a decade now and getting worse as it goes along by implementing at least part of the Scott report this past Monday, which was the sessional payments, basically a salary payment for rural doctors.

In addition to that, we need more rural doctors because the ones who are there are burning out even if we do pay them properly to do the work. But at least this government has started. This problem has been fumbled by the medical association and the hospital association and the previous governments for the last five to 10 years. It's a litany of failed negotiations where all the parties have agreed to the need to address the problem, yet somehow they weren't big enough to come together to resolve it. So at least we're moving on this one.

There's a need to move in other areas: obstetrical care. I will tell you that fewer small hospitals are doing obstetrics now than they were seven years ago, as I've just completed a 1995 study and compared that to 1988. Of the hospitals that are now still doing obstetrics, there are fewer family doctors doing them. There are fewer family doctors doing GP anaesthesia, and less availability for emergency anaesthesia, less availability for Caesarean sections in those small hospitals that are doing obstetrical care. Women's health care, including obstetrical services, has gotten worse in the last seven years. We are not making progress; we're going backwards.

Let's talk about psychiatry. It might be interesting for you to know that the population of northern Ontario is greater than the population of Ottawa-Carleton. In northern Ontario there are 49 psychiatrists. In Ottawa-Carleton there are 252. The population-to-psychiatrist ratio in Ottawa-Carleton is 2,851 to one. In northeastern Ontario it's 22,000 to one. If we go up the road to Huron county it is 20,000 to one. In London it's 3,600 to one. These are vast inequities in distribution. We need to address those vast inequities so that the rural person gets their fair share of the health care dollar, so that they get a fair chance to access the kind of health care they require, the same as very other person.

Imagine for a moment: If psychiatry services were population-based funding and psychiatry services received the same amount of per-dollar funding in northern Ontario as they did in Ottawa and the fees were prorated, we'd soon see a shift of psychiatry services, I'm sure.

Medical education: Every study around the world indicates that medical education is one of the keys to getting doctors into the country. How well are we doing

at medical education? Well, primarily it remains urban-centred and urban-oriented. We made a few steps forward, but if we look at people particularly from northern Ontario, they do a three- or four-year degree before they get into medical school in a university, usually in southern Ontario. They then spend four years in medical school, then two to five years in specialty training. After that, they spend a 10-year time in southern Ontario, and then we expect them to go back up to northern Ontario? They've already met spouses who have a professional career down in Toronto or somewhere else. It just doesn't make sense. We have to do more of their training in northern Ontario and rural Ontario, and we have to develop that now. There are proposals in front of the government now to do that. It's time to act on them.

Post-graduate training for family medicine: Again there are some northern and rural programs, but the number is far too small for the needs. Some family doctors to go to rural areas need third-year training positions such as for GP anaesthesia. They've been tremendously limited by the previous governments in Ontario. There simply have not been enough positions put forth to supply anywhere close to the needs for this. Is it a surprise that we have a shortage of GP anaesthetists? No it's not.

One of the positive things on education has been the OMA-Ministry of Health continuing medical education agreement for rural doctors that was started by 1993 with the NDP. That has been a very positive thing for rural doctors and we'd all like to see that continue because it helps fund us to get out for the kinds of education we need.

I'll talk briefly about rural practice support programs, the Ontario underserved area program: very limited targets and little improvement over many years. Twenty years ago the amount of funding they provided in that might have been an inducement for doctors to go to a rural area; 20 years later the funding has stayed the same. It simply is not as attractive as it was. It's not a surprise it isn't.

The locums program by the Ministry of Health-OMA under the 1993 agreement again is a success, but it's too small.

Coordinated rural health strategy: Other countries and jurisdictions around the world have developed a coordinated rural health strategy in the last five years. Australia has, Alberta has, closer to home; British Columbia's developing that now. We haven't even got that far in Ontario. It's long overdue. We haven't given it the thought needed, so it's not a surprise the problems haven't been solved.

In summary, the problems are multifactorial. Major education, recruitment and retention initiatives are needed and require significant resource reinvestment. We are cutting back on funding to hospitals and universities. The total health care dollars are supposed to be kept the same, according to this government's plans, and therefore there's money to be reinvested. Let's reinvest it where it's needed: in rural health care. How do we do that?

In the next part of the brief I've outlined the key points we need to address and how to do them, in a brief I sent to Helen Johns November 24, 1995. Things haven't changed a lot since then; that's only two months ago.

Under education, we need to provide rural-oriented medical education at all levels. There are proposals in front of the ministry right now in answer to the minister's letter to be considered to do that. One would include more training in northern Ontario, which is a really important idea. Other jurisdictions have done this kind of thing. In northern Norway they've successfully trained more doctors, and guess what? More of them stayed in northern Norway. These things have been proven to work. We need to get on with them now, and this bill or whatever legislation comes forth have to address these problems.

We need to do more specialty training in rural areas. One of the proposals in front of the minister is a University of Western Ontario multispecialty rural training unit, and that is the exact kind of thing the minister asked for in his letter to the Council of Ontario Faculties of Medicine.

Let's go past education to recruitment and retention. The Scott report provided an excellent assessment and provided initiatives. Under the Scott report he recommends a lot more than just a salary report for doctors doing residency work. He recommends community facilities. Is it any surprise that a doctor graduating these days does not want to go to a small town, buy or build an office, hire his own staff and then find out a year later that he can't stand the place and he can't sell his \$250,000 investment? No, it wouldn't be a surprise that they don't do that. But in communities that can provide facilities, a turnkey operation, they are going to be more likely to go there. If we can provide a guaranteed income, a contract position, we'll be able to attract more doctors to those communities.

These things are possible, they've been shown to work; it is time to get on with them. They've been almost negotiated with former governments and this government under the contract positions in the 1993 agreement, but little problems kept cropping up and they were never quite completed. It's time to complete the negotiations and get on and address the problem.

Significant sustained incentives are needed for rural practice. It's not enough to just get people there. We don't want a doctor coming and lasting for two years and in a 10-year period having five doctors turn over. We want one doctor to stay for 10 years. So we need to look at how to retain them, and we need a significant funding shift allocation to do that.

I've talked about specific areas. I'll just highlight one particular item, the CMPA premium. There's been a lot said about getting rid of the Canadian Medical Protective Association premium for doctors, and there are a lot of good arguments for getting rid of it, but I can assure you that if we take away for doctors in rural areas who do anaesthesia and obstetrics, we will take away anaesthesia and obstetrics in rural areas.

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I don't care whether the CMPA premium is paid or there's some other subsidy or inducement given for that, but you can't take it away and not provide some bonus for doing that kind of work. I like doing obstetrics; it's part of the joy in my practice. Right now, basically we do it for close to nothing because you have to do so many

deliveries to pay for the costs. If you take that away, we'll be having to pay to do obstetrics. I don't think many doctors are that altruistic. We can't take that away without having it collapse unless we substitute some bonus for doing those activities, specifically obstetrics and GP anaesthesia.

Other potential future distribution measures: Regional population-based funding would make a tremendous difference to physician allocation and distribution. For example, if you funded psychiatry for northern Ontario at the same per capita basis as you do for anywhere else, the other places would find less funding for their multitude of psychiatrists and there'd be a plethora of funding for the northern Ontario psychiatrists. We could apply that same kind of concept to funding other primary health care services such as family physician services.

Primary health care reform may also be helpful. Billing number restrictions may not have the result expected. Studies in the United States show that physicians recruited to areas because of return of bursary service or other restrictions tend to stay fewer years than people attracted to those areas. They tend to do less work when they're there, less satisfactory work, and they get out as quickly as they can. Billing number restrictions may not get the right doctors to the right places. A far better population-based incentive would be much better than billing number restrictions. However, that may be necessary to at least move the people out of the biggest, most overpopulated doctor centres.

Specialists linked to hospital privileges has both an upside and a downside and has to be carefully entered into, but it may have some beneficial effects for the rural areas in terms of getting doctors to come to areas where privileges are available.

Just to close, there's also a need for providing some rural health research. In Australia, they have come to the realization that you can't solve the problems of rural health care in Melbourne or Sydney. We can't solve the problems of rural health care with policy-based planning and research centred in Toronto, Ottawa and London. We need to have some strategically placed rural-based health care research policy and planning development, so that policies and planning and strategy are based on the needs and the issues important to rural practice and the rural health care of Ontario. Unless we do that, we'll continue to sit and come up with solutions that no longer work.

A typical example of solutions that don't work is when several years ago the government went to a two-year licensure for doctors; you had to have two-year licensure or you couldn't get your licence or finish the specialty program. Educationally this was sound, but one of the spinoffs was that it eliminated all the doctors from moonlighting in residency training in all the small towns in Ontario, which had been the salvation for the small-town emergency departments. We took that away and we got the crisis in emergency health care in small towns because the central planning body didn't quite think through the ultimate effects of that and didn't make compensatory adjustments in their planning.

My final point for rural health strategy in Ontario is that it should include and should start immediately with better education for rural doctors with more rural-oriented

education, better working conditions for rural doctors to get more doctors in rural areas, and more equitable funding for the rural population so they are provided with the basic health care services they need in the rural and northern areas.

Mrs McLeod: Thank you very much for your presentation. I think your last comment about things that are not carefully thought through applies to much of Bill 26. A good example of that is the CMPA rebate withdrawal, which looked like a politically popular thing to do, but government simply hadn't looked at the impact. As I told the committee last week, I have a bias because my husband has been a practitioner in a northern Ontario community for 30 years, does obstetrics, is delivering the babies of the babies he delivered, and would now have to deliver at least 46 of those babies free of charge before he started to see any return. Obviously, that creates concern.

I appreciate that you've presented a very positive set of constructive suggestions. I wish this forum was about receiving positive suggestions. I have to tell you, I don't believe it is. I believe this is a finance bill, as it has been presented by the Minister of Finance. Although the government talks about redistributing the dollars, the only financial statement we've had from that Minister of Finance takes \$1.5 billion out of health care for deficit reduction. The Minister of Finance has not given us any financial statement that puts the money back in.

If this were a forum about how we manage the challenges in health care, you've given us a blueprint to deal with recruitment and retention that we could build on very quickly to begin to address the problems. There have been things tried that are working, but there hasn't been a comprehensive approach. There's a 67% retention rate in the northern residency training program, which I think is a real success story. But this bill is about control and quotas and powers to decide who practises where, and I would like to ask you two questions.

First, there's concern about the ability of the Minister of Health and the ministry to work that program effectively, even if you believe in it. We heard in Sudbury, which is trying to get an underserviced area designation, that ministry data included three dead physicians and one retired family doctor who gave 'flu shots to his neighbours as full-time practising physicians, and that's why they're not an underserviced area.

Do you have confidence in the Ministry of Health's ability to handle quotas and determination of who should practise where, and do you think at the end of the day that Bill 26, hand-in-hand with coercive billing numbers, will make recruitment more difficult because more people will leave this province?

Dr Rourke: I have not been impressed in the past with the Ministry of Health's ability to micromanage health care and physician placement, for the exact reasons you gave. I'm probably as close to the data as anyone, and it is impossible to get accurate statistics; it just does not exist in a close enough way to micromanage it. Therefore we need broad incentives, broad actions, rather than micromanaging where this town gets a doctor, this town doesn't get a doctor. That just cannot work.

In terms of Bill 26's ability to do that, I have concerns that it gives a lot of power to one person's discretion rather than to groups and individuals, without recourse. But either Bill 26 or something has to be done to address the problems, and we can't go back to the way things have been done before. Action is needed now. If this is one way to get action, then that needs to be done and maybe amended to take out the sore points.

Ms Lankin: Thank you very much, Dr Rourke. As government members have pointed out and as you pointed out, this problem has been around for a long time, and a number of governments have attempted to deal with it. I recall in early 1992, when I became Minister of Health, a crisis, as it was presented to me, in terms of underserviced areas and looking for solutions to it. The very proposal we see before us in this bill in terms of billing numbers was brought forth through the ministry policy proposals to me. We explored that and the response was overwhelmingly negative, and I came over a period of time to understand why and to understand that was not the way to go.

There wasn't a consensus on a lot of what needed to be done. There were ideas. We moved ahead with the northern residency program, the CME, little pieces of it, but in terms of a more comprehensive solution really undertook the processes through PCCCAR and Scott, and I agree with you that it is past time for action to implement the recommendations of those reports.

My concern about the elements of billing number restrictions, as set out in this bill—and it's not that other governments haven't tried to use it as a gun to the head to get solutions. This bill's going to be passed in a week and a half with those measures in place, and doctors in northern Ontario, where we were last week, told us they are already beginning to relocate their billing numbers and their practices to southern Ontario, or from rural to urban, in order not to be caught by the bill, if that section is implemented, and be frozen in place. Are you aware of this in terms of rural doctors' practices? Is this a phenomenon that's really happening?

1630

Dr Rourke: Rural doctors have been among the prime candidates for recruitment from the United States because of their multiple and varied skills. There are two concerns with the billing number restrictions. Pity the poor doctor who has been in rural practice for 10 years, has done his job, he's done it well and because of life-cycle reasons he now wishes to relocate to a more urban centre for children's education or whatever. And you have the doctor who spent his 10 years in urban Ontario and billing number restrictions come in that then prevent that rural doctor, who's done his dues, from moving to the city yet do nothing to the urban doctor. That's why I'm not in favour of billing number restrictions but more in favour of recruitment and retention initiatives that are significant.

An example of those are those in Quebec, where there's a tremendous differential in payment for physicians setting up in Montreal versus Sherbrooke versus Chicoutimi. That seems to have some effect on us to work. Other incentives that are used in Quebec include a significant salary component for GP anaesthetists to make it worth their while.

I think those things are more effective, more likely to work in the long run, and if we make it financially unpalatable for people to set up initially in the city, then some who really desperately want to do that will do that, and that's okay. But I think we have to apply population-based funding more to those things and then that sort of levers the blunt instrument of billing number restrictions, which I am not convinced will achieve the effect that's desired by the government.

Mrs Johns: Thank you for being here, Dr Rourke. As usual, I learn lots every time I talk to you. I want to thank you for being here, because it legitimizes what I've been saying about a two-tier health system, people having doctors in urban Ontario and not having doctors in rural and northern Ontario. Sometimes I know people think I have holes in my head when I say that, but I appreciate the numbers that back up that process.

The minister has said that he will not implement billing restrictions if your professional bodies come up with an alternative that allows people in rural and northern Ontario to have access to doctors. Can you tell me how long it would take to implement the kind of things you're recommending? I know there are different levels so there are different time frames, but when could you see that, through the normal course of your recommendations, we would have adequate doctors in rural and northern Ontario and what do you perceive we should do in the meantime to solve the problem?

Dr Rourke: That is the major problem, the time lag. If we start an educational process that's centred more on rural and northern Ontario, we're talking a time lag of eight to 10 years to get an output at the end of that. If we're talking a time lag of putting in some funding and recruitment incentives, such as recommended in the Scott report, from a funding point of view, that can be instituted immediately and can have an immediate effect. I think for financial funding-type arrangements to have an immediate effect there needs to be not only a bonus for rural areas but a compensatory offset in urban areas. The numbers are small enough that the offset would not have to be that great to make a significant difference, but I would suggest in the order of what happens in Quebec is perhaps a reasonable incentive package. I think that can work fairly well.

There are other things that we can put into place that will have a lag time. That's an immediate one, could have an effect within a year or so. The intermediate ones are building the infrastructure. For example, the contract positions and facilities for rural doctors could be put into effect to work within about two years to have some beneficial effect there by building the kind of turnkey operations. I would say many hospitals now have lots of room because we're not keeping many people in hospital any more, and they would be the ideal location to develop rural clinics to attract doctors to work into. Those would take about two years to have an effect.

What can we do immediately? The question of whether you close off certain very oversupplied centres for a short time has been raised, and that has potentially negative effects as well as positive effects but would have certainly helped some people move out into the rural areas.

The Chair: Thank you, doctor. We appreciate your presentation here today.

Ms Lankin: While the next presenters are approaching, I just wanted to mention into the record that legislative research has provided us with some background documentation in answer to questions raised by the other subcommittee on issues of ability to pay. I've mentioned to government members a few times that I would urge them to read the Johnson commission, and I didn't have a citation for that. I would point out to you that while the full Johnson commission report is not contained herein, it is referred to in the research summary, and in the appendices, the third-last article, by Martin Teplitsky, it gives actually some quotes and quite a bit of overview of the issue of both arbitrators' treatment of ability to pay and the Johnson commission rejection of that in the 1970s. I would really urge the government members to take a look at this. I think it's an excellent document.

The Chair: Thank you, Ms Lankin.

CHATHAM AND DISTRICT LABOUR COUNCIL

The Chair: Our next presenter is from the Chatham and District Labour Council, Buddy Kitchen, the president, and David Frain, a member. Welcome, Mr Kitchen.

Mr Buddy Kitchen: Hello, Jack. How're you doing?

The Chair: I'm fine, thank you.

Mr Kitchen: Long time no see.

The Chair: You have a half-hour to use as you see fit.

Mr Kitchen: Okay. As a background, the Chatham and District Labour Council consists of 25 affiliated unions representing approximately 12,000 members. Our members come from both private and public sector workplaces. We were chartered by the Canadian Labour Congress in 1958 and have been representing the views and interests of working people in this area since. The elected officers of this labour council are not full-time positions. Although we are not confined to geographical boundaries, our organization considers the boundaries of the county of Kent to be the same. Politically, we are represented by the MPPs of Chatham-Kent and Essex-Kent.

Bill 26 is so encompassing in its contents, two sets of hearings are being held. Because this labour council represents workers in the health care industry, we made an application to appear before the subcommittee dealing with health issues.

It should be noted the labour council applied to the clerk of the committee requesting an appointment to appear before the subcommittee on general issues in either Windsor or London, the closest geographical locations to us. We were accepted and made a presentation at the January 8 Windsor hearings.

This labour council offers no apologies for making a second presentation. We have no more vested interest or influence than any other organization or citizen who made application. We simply applied for both committees and were accepted by both committees.

As an introduction, the Chatham and District Labour Council is pleased to participate in the hearings on Bill 26, the Savings and Restructuring Act.

However, we must make it absolutely certain we oppose much of the content of this omnibus bill. More

importantly, we object to the undemocratic process with which it is being forced on the citizens of Ontario. This labour council is of the opinion the window of opportunity which allowed a bill of this magnitude to be introduced lies squarely on the shoulders of the federal Liberal government and the implementation of the Canada health and social transfer. Bill 26 reaffirms our position this provincial government is autocratic and undemocratic.

These hearings are not being conducted as part of the democratic process. We are of the opinion these hearings are a result of relentless pressure by the public to be consulted and unprecedented parliamentary disobedience by the opposition parties which embarrassed the government, and for that, we congratulate them.

We question this government's integrity to implement any of the recommendations brought forward not only to this committee but the other committee as well. My proof for this statement comes from viewing the December 22, 1995, health hearings on the parliamentary TV channel.

Frances Lankin, MPP, tried unsuccessfully to introduce a motion to extend the length of the hearings outside of the Toronto area. It was already acknowledged before leaving Toronto that there were more applications for submissions than there were time slots. A very generic amendment requesting the government House leaders be advised of this information was then voted down.

This confirmed to me the government members are here to pay lip-service to the people of Ontario and conduct these public hearings but at the same time will toe the party line regardless of the information brought forward.

This act is very far-reaching in terms of content and scope. The fact it creates three new acts, totally repeals two acts and amends a total of 44 other acts verifies this. Bill 26 is over 200 pages. The compendium provided with the bill is said to be a foot thick.

Given the number of acts created, repealed or amended, and given the significance of all other issues involved, the process should allow for the democratic input of all concerned. However, we feel that with the new powers this bill will give to certain ministries within this government, certain sectors of this province are intimidated from making a presentation for fear of reprisal once this bill is implemented.

More importantly, given the number of groups and individuals who applied to appear before this committee and were not successful, and given the fact other groups and individuals are making multiple presentations, serious consideration must be given to improving the selection process to ensure all people have access to be heard. I believe, Jack, you said that in an interview on CSCO radio last weekend.

If this committee can agree with our assessment that groups and individuals are being heard for the second time at the expense of people not being heard at all, then you should have no problem agreeing with our recommendation that these hearings be extended so all people have a chance to be heard.

1640

The Savings and Restructuring Act includes substantial changes on many issues. I would like to touch on some which are pertinent to our organization, as they would

affect our members as individual citizens or as a member of an affected group.

Before dealing with specifics of the legislation, I feel it is important to make reference to the individuals whose job it is to draft, promote, debate and vote on this important piece of legislation.

The MPPs' ability to understand the legislation: I raise this issue with the greatest sincerity. There are presently 130 MPPs in the Legislature. These are the individuals who were duly elected by the people they represent and ideally are answerable to them.

Of the people elected in the last election, 71 MPPs are sitting in the House for the very first time. The Tory government has 59 members new to the Legislature and provincial politics. My MPP from Chatham-Kent, Jack Carroll, is one of them.

Would it be wrong to assume an individual such as Jack Carroll, who had no previous political experience, hasn't the ability to accept the following changes in his lifestyle and do merit to a job he is still getting used to?

Mrs Johns: He is doing merit to it. You're doing a good job, Jack.

Interruption.

Mr Kitchen: Some people say that it would be better to be quiet and let me assume you're ridiculous than to open your mouth and let me prove it.

Events such as opening constituency offices in Chatham and Toronto and hiring staff for each, familiarizing himself with his constituency because he doesn't live in it, familiarizing himself with Toronto because he is going to live and work there part-time, learning the rules and regulations of being an MPP, meeting with his own caucus and being assigned duties within, see to the day-to-day responsibilities of his constituents, attend civic functions on behalf of the government, attend the opening of the Legislature in September, meet with and listen to the concerns of protesters at his office on a weekly basis, start dodging the protesters at his office on a weekly basis, be in the Legislature to debate and vote on new, far-reaching legislation such as Bill 7, meet and try to rationalize to the Chatham city council all the provincial funding cuts, appear on radio debates with local detractors of the Common Sense Revolution, give his maiden speech in the Legislature, try to maintain some semblance of family life, chair the general government committee hearings on Bill 26 etc, etc, etc.

Ms Lankin: And they say the life of an MPP is glamorous.

Mr Kitchen: And highly underpaid.

It is probably safe to say Jack Carroll and the other 70 new MPPs are still feeling their way along in their new jobs and are apt to make the usual mistakes rookie MPPs make until they become familiar and experienced in the ways of government. In a December 18, 1995, Chatham Daily News article regarding him chairing the hearings on the controversial bully bill, Carroll said he expects to hear from "regular opponents of Conservative policies, such as union leaders and social activists." Which categories did Ministers Wilson and Leach fit into when they made their presentations?

I have written letters to my MPP, the Minister of Labour and the Premier concerning various issues. Some

letters have gone unanswered, some letters have been responded to four months after the fact and some letters have been referred to the minister involved, only never responded to. This again shows how extremely busy all members of this Legislature are.

I've made phone calls directly to the Minister of Economic Development, Trade and Tourism's office when funding cuts for the proposed ethanol plant in Chatham were announced, only to receive no response from that ministry.

It is conceivable to understand that government backbenchers and rookie MPPs could be ill-informed as to the content of this bill, but one would assume government ministers would have working knowledge of this bill, particularly if your ministry was one of the ones so adversely affected.

After the bill was introduced in the House, Municipal Affairs minister Al Leach was hard-pressed to explain direct taxes at the municipal level. He offered his resignation if he was wrong in his interpretation. According to some experts, he is dead wrong.

The charade goes on. During the first day of public hearings on Bill 26, Minister Leach again denied a suggestion the ability to impose direct taxes at the municipal level means a new class of sales tax. He said the language was just "legalese." According to a Windsor Star article of December 19, 1995, here is what happened next:

"When pressed by NDP leader Bob Rae, Leach asked for help from ministerial staff. The seat beside Leach became a musical chair as one bureaucrat after another attempted to assist Leach as he struggled to explain the bill."

The Ministry of Health is another ministry which will receive new, far-reaching powers. One can raise issue with the fact the Minister of Health will be able to control a health care delivery system which is the envy of the world, dictate in certain aspects of it, yet holds no medical degree nor comes from a medical background.

To conclude this section, we feel the elected officials who vote on this ominous piece of legislation are inexperienced and lack the knowledge and expertise to evaluate this bill at this time. They don't know their job yet and they're still making mistakes in the day-to-day workings of the basic MPP job. Having only sat in the Legislature approximately three months since being elected, their time has been quite busy dealing with the legislation before them. The MPPs, including the ministers who should know, are ill informed about the content and intent of this bill. If the larger staff an entire ministry has cannot explain the pertinent sections to that minister, as was the case with Minister Leach, is it conceivable the average MPP, without the expertise of the ministry's staff, be able to comprehend the entire bill?

The Chatham and District Labour Council recommends to this committee that, at the very least, this act should be broken down into its various components and debated as such.

One also must question who is in control of the direction this government is going and who is really calling the shots. I have been told by my MPP he would

not vote against government legislation even if it was bad for our riding.

This scares me when I read a London Free Press article on December 16, 1995, entitled, "'Whiz Kids' With Inside Track to Harris Raising Resentment." This article talks about "the unelected insiders, highly influential...who advise the government on policy and how to implement it." I wonder how much of this pertains to Bill 26. It scares me to think that they could impact a bill of this magnitude when I read the following quotes:

"Politics is strictly just one big game to them. I'm speaking of Alister Campbell, Mitch Patten, Tom Long and Leslie Noble.

"It is this outside group...who are saying: 'Ram this stuff. Do it.'"

"There are too many people with too much input who have never even been elected dogcatcher in their life. They have no constituency to answer to," said a Tory backbencher.

"They don't understand the democratic process," a Tory MPP said.

Reference has been made to this committee that this bill is a power grab which will put the power in the hands of the ministries and thus the hands of the unelected bureaucrat. If this is the attitude of the unelected power brokers of this government, something has to be done to stop them.

Freedom of information: Bill 26 amends two separate acts concerning freedom of information and the protection of privacy. In essence, these amendments will make it harder to gain access to documents and easier to deny access. One should offset the other, not reinforce it.

Schedule K is the section which gives the Minister of Health new powers to obtain confidential health information and give it to whomever he chooses.

Allow me to share this information with you: I am a recovering alcoholic. I received treatment at Westover Treatment Centre in Thamesville, Ontario. I've been sober since receiving treatment in April 1993. You now know this information about me because I've told you, not because some Minister of Health obtained it from my files without my consent.

As a recovering alcoholic, I must tell you, to some anonymity is an important part of their recovery. Anonymity, much like protection of privacy, once it is breached, can never be recovered.

Pensions: The amendments to the Public Service Pension Act and the OPSEU Pension Act facilitate the privatization and downsizing of government employees. If the government lays off the thousands of employees it says it is going to, they will have the authority to deny full pension benefits to those people. Employees should be entitled to all money owing them, particularly if that money come from pension sources.

We understand that when the government tried to make the same changes to the pension acts by regulation last summer, they were beaten in court by the Ontario Public Service Employees Union and their actions found to be totally illegal. We find it ironic to see a government which campaigned on MPP pension reform and is still

struggling with how to achieve that, suddenly become pension experts when their employees are involved.

1650

We recommend to this government that rather than legislating pension changes to your employees, become a responsible employer and enter the changes into the collective bargaining process. Make the pension plan part of the collective agreement, subject to the members' approval. After all, this will allow members of the plan an opportunity to democratically vote on changes to their plan, much the same as you will when the changes to your pension plan are brought before you.

Municipalities: Section 33 of the bill makes privatization of public utilities such as hydro, water, sewer and, in some municipalities, transportation services much easier. Disregard the fact it was the taxpayers who paid to install and maintain these utilities over the years, and disregard the fact that proper market value could probably never be found, but you cannot disregard the fact the amendment takes away the requirement to hold a municipal referendum. What could be more anti-democratic?

Conservation authorities have had their funding slashed 70%. This bill will now limit the levies they can charge the municipality. This means their source of income will primarily be the decreased provincial funds, whatever voluntary municipal funds are available and increased user fees. This can only lead to the shutdown of many of these authorities. It would be sad to see these areas, which were developed by local residents for local residents, shut down. But the question must be asked, what becomes of the assets?

Restrictions on arbitration: Despite the fact that of those affected by these amendments to the five different acts, this labour council represents only hospital workers, we must oppose the significant interference with the independence and integrity of the arbitration process. This legislation could force arbitrators to cut wages of these workers or, worse yet, consider whether fire, police, school and hospital services should be reduced. This places the wrong decision-making power in the wrong hands.

Health care: The Chatham and District Labour Council believes in the five cornerstones of medicare spelled out in the Canada Health Act. We also endorse the Canadian Health Coalition's Ten Goals for Improving Health Care. A copy is included in this package.

We oppose the changes to the Ministry of Health Act which create a Health Services Restructuring Commission. One would assume this is designed to provide a cover for the government on unpopular decisions like hospital closings. We oppose changes in the Independent Health Facilities Act which we argue set the tone for American for-profit companies to take over more of Ontario's health care.

We oppose changes to the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act, 1991. As advertised, this introduces copayments for seniors and social assistance recipients. It also deregulates drug prices. When the Drug Interchangeability and Dispensing Fee Act takes effect, Ontario will be the only province that does not

regulate drug prices. There is no reason to believe deregulated drug prices will go down.

We oppose the implementation of user fees of any sort. Some will say the implementation of such violates the Common Sense Revolution. Our studies reveal user fees do not deter abusers, so to implement them as a policing agent for abuse is ridiculous.

We also see user fees on prescriptions as a punishment for being sick. Jack Carroll, MPP for Chatham-Kent, sees this differently. Despite the fact he is not a doctor, in a December 1, 1995, Chatham Daily News article, Carroll said the reason behind the user fee is to ensure the drugs are absolutely necessary. He is quoted as saying, "It causes us to think, 'Do I really need this?'" The need for a prescription should be determined by a trained professional, not by the whim of a newly elected politician.

The implementation of user fees could lead to the closure of small, independent pharmacies, as larger chain-store-type pharmacies have the capability to absorb or discount the fee. The Physician Services Delivery Management Act treats the doctors like the Leamington mushroom workers who were decertified with the repeal of the Agricultural Labour Relations Act. It voids the Ontario Medical Association's agreement, strips the OMA of any negotiating rights and says any judge's ruling, decision, award or order to the contrary "shall be of no force or effect."

It seems when this government has problems with groups or organizations, the easiest way to deal with the problem is to legislate them out of existence rather than sit down and endeavour to reach an agreement.

In conclusion, Bill 26 represents a large power grab and redistribution of power for Ontario politicians. There is an attempt to centralize power into the hands of the ministers of the crown. When that happens, the power really lies in the hands of the unelected bureaucrats, not the duly elected officials. As pointed out, the unelected power brokers of this government can't be trusted by their own people.

In this case, what happens to the principles of democracy? They become sacrificed by a few for the benefit of a few. The government holds no constituency. They answer to themselves and democracy stopped when the ballots were cast. It is because of these actions that the Chatham and District Labour Council holds the government of Ontario in disgust as a government that cannot be trusted and a government that refuses to consider all the residents of this province when setting policy.

Ms Lankin: Thank you, Buddy. You didn't read the next line, which was, "Respectfully submitted, Buddy Kitchen." I'm sort of tempted to offer to substitute for the Chair and to let him say a few words. I think it might be entertaining for all of us.

Mr Kitchen: My quotes are backed up by newspaper articles.

Ms Lankin: Yes, we saw that here, and that's very helpful. You are frank and forthright, as I've always known you to be, and I appreciate your sense of humour, but these are very serious issues that you've raised.

I was speaking to some folks in Toronto who were talking about their analysis of the government's approach. Bill 26 was but one example of it. You touched on it in

the end. They identified three things. One was a divide-and-conquer approach. Yesterday in Windsor we had these brochures, which I notice the government's not handing out today, that said, "Ten Great Things About Bill 26 the Vested Interests Don't Want You to Know." So you're a vested interest. Why are you a vested interest? Because you oppose. If you were here agreeing, then you wouldn't be a vested interest; you'd be ordinary folk.

The other things is perpetuating myths. I have to tell you I hear it over and over again in terms of some of the things the government argues around aspects of this bill.

But the third thing, and a really troubling thing, is this issue of transfer of power. I see it in many actions that the government has taken, and you've addressed it specifically within this bill. I'd like you, if you could, to comment on those aspects in terms of the balance in communities and the role that groups representing workers play and what it's like when you're called a vested interest, and this transfer of power that we see in this bill and other actions and what it means for ordinary working people in Chatham-Kent.

Mr Kitchen: Vested-interest groups, special-interest groups—we've heard them all. It seems like if you're minutely opposed to any direction this government has taken, you're automatically a special-interest group. I would suggest that, given the makeup of this government, they are a special-interest group of themselves—and there's no doubt about that. Given the direction that their policy is taking them right now, it is serving only one special-interest group, and that's not the majority of the people of Ontario.

With letters to the editor of the Chatham Daily News, there was a letter written by a Dr Evans recently that more or less said, by and large, "We were the ones who supported you in the last election and now you're passing legislation that's even opposing us." Where do the special-interest groups stop when they're not even listening to their own supporters? There's only one vested-interest group that's being promoted, and that's this government.

Mr Kitchen: I really scares me. It scares me when I read these articles on the power brokers—

The Chair: Next question, Mr Kitchen.

Mr Kitchen: Pardon me?

The Chair: Next question. Mr Clement.

Mr Kitchen: Oh, okay.

Mr Clement: Sorry to interrupt you. Did you want to finish your sentence?

Mr Kitchen: I've already been interrupted twice now, so that's fine; go ahead.

Mr Clement: Okay. Can I interrupt you by just suggesting that I appreciate your comments? Certainly I've been around this table now for two and a half weeks. It should come as no surprise to say that not everyone has agreed completely with the government's position; in fact, quite the opposite in certain cases, and yours is one of those. But I respect your position, and it's important in a democracy that the government continue to be exposed to your point of view, so I thank you for bringing your message to this committee.

I've noted all your criticisms of the bill and I thank you for that. I wanted to get to some solutions to the situation in which we find ourselves. I noticed your reference to the Canadian Health Coalition, Ten Goals for Improving Health Care. I'd like you to turn to that, if you could. I just want to get an expansion of your opinions about these particular items. For instance, number 6 is, "Ensure fair wages for all health care providers." In your opinion, how is the best way to get to that? Do you think unionization is part of the answer or is that irrelevant to the issue? How best to allocate the resources, which are scarce by any standards, to help the health care providers?

1700

Mr Kitchen: I'm not necessarily saying that unionization is the answer to everything, if that's what you're trying to get to.

Mr Clement: No, I'm just asking you.

Mr Kitchen: All we're saying is that health care providers be paid a fair and decent wage for the work that they're doing. If you read what it says here, it's "being shifted on to poorly paid workers in the community and unpaid family caregivers in the home, most of whom are women." I don't think you could disagree with that, could you? "Health care reform should not rob communities of 'good jobs' and contribute to the development of a low-wage economy. Wage parity with existing institutional jobs recognizes that fair wages and decent working conditions contribute to a quality of care."

Mr Clement: Absolutely.

Mrs Papatello: I had an interesting conversation, Buddy, with London Life this morning. They were here. I see on your shirt you have "CAW." You are a member of the CAW. We were talking about where the costs are really going for anything that's going to be delisted in terms of health service or drugs. I want to get your opinion, you either agree with this or not, and that is that anything that's going to come off in terms of a drug that is still required or that your employees are going to want as a part of their package, any kind of health services that are going to come off as a result of this or as a result of the minister's decision, is going to be wanted by your employees and asked for and negotiated for the next time you get into contract talks with the Big Three or whomever. Your success rate in terms of negotiation is probably one of the best in North America. The likelihood of your getting that kind of coverage is probably good, that it would be extended.

That was the problem with London Life, because they recognize that. What's going to happen is that eventually they, as the insurer for the employer, are going to have to encompass additional drugs that are not being covered for now. They'll have to include that as a part, without raising or changing the premium, or the individuals simply don't get it and they pay for it themselves. So we're just shifting the cost burden on.

But in the case of a powerful private union like the CAW, the likelihood is that you'll be able to cover that, in which case that cost moves directly to business, and this bill indeed is bad for business because it has in it the ability to move the cost to the employer.

Mr Kitchen: There's a lot of truth to what you're saying, but let's not fool ourselves. Because a workplace is represented by the CAW, that doesn't necessarily mean that it has a negotiated drug benefit plan. Many of the plants that CAW represents do not necessarily have a negotiated drug benefit plan. Other ones that—

The Chair: Thank you, Mr Kitchen. We appreciate your attendance here today.

Mr Kitchen: Oh, boy, I've been cut off by better.

LONDON-MIDDLESEX TAXPAYERS' COALITION

The Chair: Our last presenter for the afternoon is the London-Middlesex Taxpayers' Coalition, represented by Jim Montag, the president, and Robert Metz.

Mr Jim Montag: Good afternoon. I am Jim Montag and with me is Robert Metz. We both represent the London-Middlesex Taxpayers' Coalition. We are here today to offer our assessment of the medical portion of Bill 26.

Ontario's cost for health care is slightly more than \$17.5 billion. The direct payment to doctors alone is \$4 billion. The cost of health care for Ontario is the single biggest government expenditure. This is more than what Ontario spends on social services and the entire education system. Clearly something must be done to control this expense and to prevent any cost escalation.

I quote from the November 1995 Fiscal and Economic Statement by Ernie Eves, Minister of Finance: "The government is committed to maintaining health care spending while aggressively eliminating waste, duplication and inefficient practices. Health care will focus on direct care for those in need and on preventative care." This is a commendable goal and we wish them success.

If we don't control spending and reduce the deficit, we may be faced with an alternative solution. That would occur when the International Monetary Fund and the world bankers do it for us. Their cuts would be much more severe than any plan by our government. We need only look to New Zealand for an example.

You have heard and will hear from many groups protesting the government's proposals to control the cost and to remedy the weaknesses in the system. These are mostly self-interest groups with their own agendas. I really can't believe that they have any other than their own interests at heart.

For example, doctors would have us believe that they are deeply concerned with patient confidentiality if patient records are examined by inspectors. However, I believe their real concern is that examination of patient records would enable inspectors to investigate billing practices.

The Ontario Medical Association is seldom regarded as a union. However, it is one of the most successful unions that we have. It has consistently worked to prevent competition and to keep costs high. Once a very powerful lobby, this medical union has lost a considerable amount of its influence when faced with increased control by the government. Obviously, they resent this. With reference to their oath, I wonder if some of the medical profession is confusing the word "Hippocratic" with "hypocritic."

I see nothing wrong with doctors being required to work in remote localities for a few years after graduation.

Even bank managers have to work in small communities at the start of their careers.

Many medically intensive treatments recommended by doctors for their patients are not utilized by the doctors themselves when they are afflicted with the same illness.

The drug aspect of Bill 26 will, for some, mean a \$2 prescription fee and a \$100 annual cost-sharing payment. This appears to be a user fee, and we agree with this concept. These minimal user fees do little harm and go a long way to prevent abuses. We also agree with the plan to no longer pay for more expensive drugs if a less expensive alternative is available. This is plain common sense and something we all do with comparative shopping.

Most of the funding for research and development is directed towards medically intensive treatment and very little is spent on prevention. We believe that a research dollar spent on prevention is better than a dollar spent on treatment.

If I talked about all of the weaknesses in the medical system that I'm aware of, we would be here for a long time. We feel that the provisions of Bill 26 will go a long way to assist the government in its efforts to correct the system.

If Ontario is required to pay all of the expenses for a medical care service, then surely it must have the right to control, regulate, direct and investigate the system. When health care and treatment are free, ways must be found to control the unlimited demands placed on a limited service. After all, he who pays the piper calls the tune.

I would now like to call on Robert Metz for his portion of this presentation.

Mr Robert Metz: In September 1989, Canadian doctor Dr William E. Goodman described Ontario's health care system to an association of American doctors in the following way: "In economic terms, it is an open-ended scheme with closed-end funding. In other words, the potential demands are completely unrestricted, but the money to pay for them is not. It's like giving the public a no-dollar-limit, no-responsibility-for-payment medical credit card, an open invitation to unlimited abuse by both patients and doctors."

In 1992, Canada's provincial health care ministers attending a conference in Banff, Alberta, concluded that Canada's national medicare system would be bankrupt by the year 2000. It is now 1996, and despite its shortcomings, socialized medicine continues to be highly popular in Canada and is even gaining popular support in the United States.

1710

As Dr Goodman explained in 1989, most people don't understand its long-term effect on their lives, their liberties, their access to first-class medical care or even on their pocketbooks. All they know is that they had to pay nothing out of pocket at the time and place of actual medical service, at least initially.

The vast majority of Canadians had and still have similar difficulties in associating free benefits on the one hand with massive increases, taxes, public debt and inflation on the other. They do not understand that their rapidly decreasing access to first-class medical care is an inevitable consequence of these free benefits. Fortunately,

we now have a government in Ontario that is acknowledging the latter reality. "Health care dollars will focus on direct care for those in need," says Minister of Finance Ernie Eves's 1995 Fiscal and Economic Statement.

If this is indeed the direction being pursued by this government, we applaud it. We would remind the government that the public clamour surrounding its new focus in funding does not indicate true need but is simply a predictable result of past governments undertaking to cover everyone for everything regardless of cost.

It is interesting to note that the very concept of directing health care dollars to a specific target, be it the needy or some specific medical procedure, violates the principle of universality. But if we are sincere about our desire to help those in need, universality must be abandoned in favour of a multi-tiered system. Given this government's commitment to aggressively eliminate waste and inefficiency, perhaps it's time to stop for a moment to consider how utterly wasteful and tragic our political commitment to universality is. Under universality, we all lose. As taxpaying citizens, we're forced to support a myriad of social programs invariably justified to help those in need. However, under universal medicare the concept of directing help to those in need is completely abandoned. Universality precludes helping just those in need; it's for everybody.

How can we expect to help those in need when we commit ourselves to squandering billions of dollars on providing free government services to all? Who's holding up the safety net if everybody's inside it? Clearly, universality is no friend of the poor, needy or the disadvantaged. The truly needy have absolutely nothing to fear or to lose by cuts in government spending or by a government that wants to focus its spending specifically on them. For them, such a change would be a win-win situation. Yet you have been faced by a myriad of special interest groups, each insisting that the needy will become victims and lose out by such an approach. "We must protect our universal social programs at all costs," they insist, and in so doing, they offer themselves as prime examples of how the needy get pushed out by the greedy.

One look at the vast majority of the groups that have been permitted to speak before the standing committee will paint a picture that's worth a thousand words. I have a list there before you, but I will not read the entire list. I will just focus on a few, for example, Association of Ontario Health Centres, Canadian Union of Public Employees, the Medical Imaging Clinics of Ontario, Ontario Public Service Employees Union, Ontario Nursing Home Association, Toronto Conference of the United Church of Canada, York Region Coalition for Social Justice, Mytec Technologies Inc, and on and on.

Though all of these groups claim to speak for the needy in some way, the real thing they all share in common is a desire to continue their existence at the public trough. Despite their sentimental pleas and display of concern for the needy, I'd be willing to bet that each and every one of these groups is absolutely committed to the doctrine of universality.

In keeping with the theme of increased efficiency in government health care spending, we would propose for

your consideration some of the following alternatives and options to assist in your efforts to get the most value for these health care dollars.

(1) Reintroduce some form of extra billing and user fees. With any form of medical insurance, whether public or private, payment for small claims is also highly inefficient. For example, with car insurance, those insured expect to pay a deductible for small and/or routine matters. In this way, we can rest more assured that more funds will be available to cover the costs of catastrophic illness that might otherwise lead to financial ruin. That is the whole purpose of insurance: a common sharing of major expenses without wasting funds on minor and routine services.

(2) Eliminate government funding for many elective procedures, from cosmetic surgery to abortions, which should be paid for on a user-pay basis or by a private insurance plan.

(3) Insure the patient, not the system. By this I mean that patients should receive copies of all medical billings relating to their claims on the system and that they should authorize them before payments for their services are rendered.

When I was covered by a private dental plan, my dentist was not permitted to remit a claim to the insurance company without first getting my authorization on a claim form that specifically outlined the procedures performed and the amount being charged. It's only common sense, and it goes a long way towards preventing fraud before it happens.

It must be said in conclusion that fundamentally the London-Middlesex Taxpayers' Coalition supports a totally private medical system, with government assistance directed only to those in demonstrable need. However, our preceding comments and suggestions acknowledge that this final and ideal option is not within the purview of Bill 26, nor within the mandate of this government. Nevertheless, we urge you to avoid painting yourselves into a funding corner with no options by preparing yourselves for the inevitable future. We hope our suggestions perhaps, in addition to offering alternatives within the current government medical monopoly, plant the seeds for future debate and consideration of this most worthwhile final option.

Mrs Ecker: Thank you, gentlemen, for an interesting presentation. Having come in to listen to the tail-end of the Chatham and District Labour Council and hearing yours, I think we can truly say that this committee has heard both extremes and a wide range of opinions in between in terms of suggestions and recommendations for the health care system.

One of the things you talk about is insuring the patient and not the system and having patients receive copies of medical billings and stuff. One of the concerns that has been highlighted is misuse in the system, and when I use the term, I use it very generally to include not only any misuse that might be occurring by providers but also misuse by consumers. One of the figures I have is that, for example, in one month 7,000 individuals in Ontario used five or more family physicians, which most people would agree is a fairly serious, interesting use of the system.

How do we get at this sort of consumer use or misuse of the system in the most appropriate way? You've mentioned one suggestion about receiving copies of all medical billings and things of that kind. Are there other suggestions you have for how we might look at that concern?

Mr Metz: Unfortunately, within a medical monopoly, you are kind of backed into a corner, because you have this unlimited demand on limited resources, so what the government is forced into trying to do right now is to limit the demand as well. The only way you can do that is pretty much by doing what Bill 26 suggests right now. That's the inevitable outcome and the inevitable result of adhering to this principle of universal socialized medicine that pays for first dollar right up front.

It's an unaffordable system and to suggest alternatives within it is very restrictive. However, if we were in a multi-tiered system, you would have a situation where, for example, the government would concentrate its resources on the people in need. A fact that's very overlooked by most Ontarians today is that before we had socialized medicine in Ontario, which was 1967, 82% of Ontarians had private health insurance that covered their basic health care needs and would include costs for catastrophic illness. If the government was really concerned about making sure that everyone was insured, they would've concentrated on that 18%, but instead they sold us a plan for 100% of the people.

We have to get back to more user fees. We have to deregulate the medical industry, the research industry. There are infinite options if you're talking about options within a free market system. But if you're talking about options within a government monopoly, you get one.

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Mrs Ecker: You also suggest eliminating government funding of many elective procedures. How would you suggest that kind of activity should ever take place? The difficulty, and one of the things we've certainly given a commitment to, is that the decision about medically necessary is a physician's decision, and you're wandering into territory which many people would say is inappropriate to discuss in this kind of debate. Many of the people who have come forward to this committee would reject quite strenuously what you're suggesting. Do you think that is feasible?

Mr Metz: I agree with you that what is to be determined is medically necessary is definitely a decision between a physician and the patient. However, what is to be covered by insurance is a decision made, normally, by an insurance company, and the person who is getting the insurance claim knows in advance what he's covered for and what he's not covered for.

I think we're talking about two different decisions. It's a misnomer, almost, to be saying we're here talking about health care. We aren't at all. I dare say Jim and I don't know too much about particular medical procedures and that most people around this table do not either. The issue we're talking about here is money and funding and economics, and how to get money into the health care system we have. Unfortunately, government is blocking ways of money getting to the system by banning things like extra billing. On the face of it, it seems ludicrously

absurd that we would prevent people who are capable of doing so from giving money and pouring more money into the medical system.

Mrs McLeod: I acknowledge that I come with a different perspective than you bring to the table, right off at the very beginning. I don't know what special-interest group you'd like to slot me into, but I am absolutely, unapologetically committed to the doctrine of universality as you have described it.

I appreciate that in your brief you have underscored, for those of us committed to ensuring that the best is available in health care regardless of ability to pay, how that commitment is going to be challenged by the provisions of Bill 26. I also agree with you that unfortunately we're not here to talk about health care, even though this bill radically restructures our health care system. This is about money. That is also what I have been saying for about 10 days on the road.

Having declared my own bias, however, I'd like to ask you some questions about your sense of the bill from your own perspective, whether you would have concerns. Before I do that, because you note that you see nothing wrong with doctors being required to work in remote localities for a few years, I want to mention the fact that I'm a northerner. I come from northern Ontario and have been involved in recruitment and retention of physicians for a long time. I've just come away from a full week of hearings across the north, and there's nobody in northern Ontario who wants doctors who have been forced to work in northern Ontario. We think there are better ways.

I'd like to ask you a couple of questions, so I hope we have time. You've touched on the fact that you don't have a lot of concern about the access to doctors' records in the name of dealing with fraud. This bill provides significant access to patients' confidential medical information. To be very specific, whereas in the past the general manager of OHIP was able to look at a doctor's billing records and challenge the billings and then refer to the Medical Review Committee to say whether this was medically necessary, this bill now allows the minister to send investigators right into a doctor's office. Those investigators can look at not only a doctor's billings but his charts and notes on patient care and the patient's condition, can take those out of the office, copy them, can then disclose them for reasons the minister deems to be in the public interest, and there is no liability for misuse of the records, no liability to either the inspectors, to the Minister of Health, to the staff members, or to any other individual, and I'm quoting the act directly. It's one of those things you end up having committed to memory.

I'm wondering if you don't feel those powers are somewhat excessive and a grave violation of right to privacy and go far beyond what is needed to deal with concerns about inappropriate billing.

Mr Montag: No. I really don't agree with that. Many other government branches have those powers. The income tax department has the same power to go into a business, to take out the records, to examine them, so why should the medical profession be different? If we're dealing with a government that has to pay for the system, they certainly should be able to police the system. I trust the government, that it's not going to disclose my income

tax records to other people. I think I would trust the government commission that it would not disclose medical records to other people.

Mrs McLeod: Some of us become concerned when the government in its own legislation sees the necessity of absolving itself or anybody that works for it from any liability for inadvertent disclosure or misuse of confidential information. Confidentiality is held inviolate by others who had access to confidential information.

Mr Montag: They do that for every group that has investigative powers. They absolve the police departments. They absolve the RCMP. They absolve the income tax department. You can't sue them.

Mrs McLeod: I think you'll find that the privacy commissioner feels the powers go far beyond what are granted anywhere else.

The Chair: Thank you, Mrs McLeod. Ms Lankin's turn. I presume Ms Lankin. Is it Mrs Boyd?

Ms Lankin: No, I'm just—

Mrs McLeod: Speechless. A rare thing.

Ms Lankin: I was thinking about your response to Mrs McLeod about the privacy of information. I wonder if I could come at it this way.

What I know about you two gentlemen, your political affiliations with the Freedom Party, runs counterintuitive to what I think you believe in, so I'm a bit perplexed. What is it about the current system of review of doctors' billings and the financial information—which in fact can already be done; you can go in and look at the billings and the financial accounting in a doctor's office—what is it that's not sufficient to deal with the problem?

Mr Montag: I'll simply state that I think it's totally inadequate to police this system with the current system.

Ms Lankin: But your response to Mrs McLeod—and I'll give you time; I won't use up all the time. I'm just wondering if you actually realize that we're not talking now about the financial billings and what the services are in the billings and checking that out. That's one thing. We're actually talking about the doctor's notations about what you said as a patient and what was wrong with you and the nature of the bug you caught or the disease you caught or the mental problem or the home problem you discussed. Those are the records now that you couldn't look inside before; you could look at the services provided in the billings and check that out. Why do you support the Minister of Health seeing that information?

Mr Montag: We already are doing that with regard to the dental system, and they're doctors as well. When you go to a dentist you authorize treatment and the dentist prepares a bill, and it says clearly on the bill what the treatment was and you have to sign that and then either they send it in or you send it in. This disclosure is already there in dentistry.

Ms Lankin: I think you're confusing a couple of things, or maybe I'm not being clear enough. The idea that a patient would sign off the billing or something like that, that's one suggestion you made and that's something

the government could consider. I'm asking you why you specifically support this government taking steps to open up the confidential part of patient information inside the doctor's record—not the billing, not the accuracy of whether the service was done, not the financial account, but the actual personal health information. Why is that necessary for the Minister of Health to have and to be able to disclose? Why do you support that?

Mr Montag: Like I said, it's already done in the dental industry. The records are there.

Ms Lankin: No, it's not. I'm sorry. You're talking about the billing information, the code of that billing.

Mr Montag: I was talking about medical records as well. A dentist keeps medical records and this is on the bill, what the procedure was. I just believe it gives the government more power to find abuse and fraud in the system. It gives them a total record.

Ms Lankin: I think we understand something different about what is actually happening in the bill, and that's fine; it's a very complex bill and there are different thoughts about what's contained within it.

This is not meant to be a facetious question, but I'm interested in the way you've labelled every other group that's come forward as a vested-interest or a special-interest group. Do you exclude yourselves from that definition?

Mr Montag: Not really. The taxpayers' coalition has an interest. We are interested in accountability for our tax dollars. We are much against the waste of tax dollars and we are interested in accountability, and that's been our purpose from the very start of our organization. We're not against taxes; we know we have to pay taxes. We ask for a service and we have to pay for it. But we've found that in many areas these tax dollars were squandered, and this is our main concern. We feel there are many abuses in the system, and with this bill the government is asking for certain powers to correct the abuses in the system.

The Chair: Thank you very much. Our time is up for this afternoon. We appreciate your attendance here this afternoon, gentlemen, and your interest in our process.

Mrs McLeod: I apologize. I've been in and out of the committee this week, and I'm not sure whether there's been a pattern of acknowledging when a written brief has been presented by somebody who was not able to make an oral presentation.

The Chair: We have not done that, but—

Mrs McLeod: May I? I happen to notice that there is one written brief which has been tabled by Mr Keith Oliver. I just feel that when somebody has gone to the effort of tabling a written brief, we should note for the purposes of Hansard that that brief is available to anybody who would like to read it.

The Chair: Thank you, Mrs McLeod.

We stand adjourned until Kitchener, our next port of call.

The committee adjourned at 1730.

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STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

Marchese, Rosario (Fort York ND)

*Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Johns, Helen (Huron PC) for Mr Danford

Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

Boyd, Marion (London Centre / -Centre ND)

Caplan, Elinor (Oriole L)

Crozier, Bruce (Essex South / -Sud L)

Cunningham, Hon Dianne (London North / -Nord PC)

McLeod, Lyn (Fort William L)

Pupatello, Sandra (Windsor-Sandwich L)

Wood, Bob (London South / -Sud PC)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Fenson, Avrum, research officer, Legislative Research Service

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First Session, 36th Parliament

Assemblée législative de l'Ontario

Première session, 36^e législature

Official Report of Debates (Hansard)

Wednesday 17 January 1996

Journal des débats (Hansard)

Mercredi 17 janvier 1996

**Standing committee on
general government**

Savings and Restructuring Act, 1995

Health issues

**Comité permanent des
affaires gouvernementales**

Loi de 1995 sur les économies
et la restructuration

Questions concernant la santé



Chair: Jack Carroll
Clerk: Tonia Grannum

Président : Jack Carroll
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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Wednesday 17 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Mercredi 17 janvier 1996

The committee met at 0859 in the Valhalla Inn, Kitchener.

SAVINGS AND RESTRUCTURING ACT, 1995

LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Good morning, everyone. Welcome to the hearings on Bill 26 conducted by the standing committee on general government. We are delighted to be in Kitchener this morning. We have a couple of motions by Ms Lankin to deal with very quickly, and then we'll get on with our first presentation.

Ms Frances Lankin (Beaches-Woodbine): You just need Ms Lankin to deal with them. Thank you, Mr Chair. My motion is as follows:

Whereas there has been overwhelming public interest in Bill 26 and that 36 groups and individuals have requested to appear before the standing committee on general government in Kitchener, which far exceeds the 15 spaces available today for hearings;

I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged for the community of Kitchener;

Further, that this committee recommends that the three House leaders meet as soon as possible to discuss this issue.

The Chair: As with yesterday, in the interests of time, do we have all-party consent for one-minute statements?

Mrs Elinor Caplan (Orillia): Oh, sure.

Ms Lankin: I fully predict, prescient as I am, that the government members will defeat this motion, as they have in other communities. I should make it clear that I have moved this motion with respect to other communities, because in every community we've gone into there has been a long list of presenters who will not have the opportunity to be heard before this committee but who would like to have their voices heard.

It's true that as the hearings go on, we've had an opportunity to hear from a wide variety of people and we

are seeing some very important themes emerge with respect to concerns the public has with the legislation. But I remain amazed that every day there is still something new, a different angle, a different understanding, a different implication the act has for a particular group of individuals or a circumstance within our society and our communities of which this committee was unaware before that presentation.

I also think we have not had the opportunity to look at some parts of the bill in depth because the presenter is only having half an hour. It is true that they are focusing on the most pressing and the most important issues to them. I believe certain of these areas are so important in terms of public policy that they deserve to have a greater in-depth study, so that's why I'll be supporting the motion I've tabled today.

Mr Tony Clement (Brampton South): I appreciate the direction in which Ms Lankin is going, but I have problems with her premise. The presentations we have heard thus far, in the close to three weeks of hearings, which have been public hearings, have been of a high quality and have grappled with the issues at hand very well, both for and against the government's position. From my perspective, the whole process is working well. By the end of this week, both sides of the committee will have heard from 750 presenters, from a wide range and multiplicity of views.

From my perspective, it is now time to grapple with some of the recommendations that have come from the presenters, which we'll be doing next week in clause-by-clause. Ultimately, we as legislators have to act and have to choose the path we are going to take so we can reform the health care system for the benefit of all Ontarians.

Mrs Caplan: We've dealt with similar motions. We had motions at the very beginning of these hearings to extend the time once the tremendous demand across the province became obvious. We know it was the government's original intention not to allow public hearings across the province at all. I find it personally very frustrating that once the government realized the extent of interest across the province, it has refused to extend the hearing hours to allow individuals and groups to attend. They have done that, obviously, because they consider the presenters who are coming to be vested interests. I think that's objectionable and an insult to the people who definitely have an interest and should have an interest in this legislation.

I know the government's going to defeat this. Some would say, "Why are you even debating it?" It is important that we put on the record how distressed we are that the government has chosen to stifle debate and to stop people having access.

I would also point out that a package of bills, the advocacy, consent to treatment and substitute decision legislation, while important, compared to this deals with one health issue, whereas this bill deals with a dozen health issues. On that bill the government allowed three full weeks of public hearings, that bill alone. We appeal to the government and ask them to look at the precedent they have established in allowing adequate time on important health issues. Hopefully, they will take that message to their House leader.

Our leaders at the very beginning agreed that if there were really essential things the government had to—

The Chair: Ms Lankin, we agreed on a minute apiece. We're into three minutes.

Ms Lankin: That's Mrs Caplan, Mr Chair.

The Chair: Mrs Caplan, rather. Sorry.

Mrs Caplan: They could be dealt with on the 29th, but this could still be split and we could come back on those issues that truthfully do not have to be passed on the 29th. I will be supporting the motion.

The Chair: Ms Lankin, you used up a minute and a half of your minute too.

Ms Lankin: I noticed that. The government's concern about vested interests and special interests is very upsetting to me, and the sorts of groups that aren't going to be heard today, these vested interests, are groups like the Halton Regional Coalition for Social Justice, the Kitchener-Waterloo hospital nurses, the Kitchener-Waterloo Pharmacists' Association, the Ontario Social Development Council, St Joseph's Health Centre—lots of individual requests; it goes on and on. I think it's an inappropriate categorization. You know the numbers, Mr Chair: Over 1,000 groups and individuals applied to be heard these two weeks of hearings and there were less than 300 committee spaces.

We believe there are major ramifications in terms of public policy in the delivery of health care services that deserve to be understood in depth, to be debated and amended appropriately, not by the process the government has set out, which is not only less than satisfactory, I would argue it's less than democratic.

I hope the government members see the light today and support my motion, but I'm not holding my breath.

Recorded vote.

Ayes

Caplan, Lankin.

Nays

Clement, Ecker, Johns.

The Chair: Just for the information of the audience, the people who voted were the only people eligible to vote. The motion is defeated.

The second motion, and maybe we could stick to the one minute on this one out of respect for our presenters.

Ms Lankin: Whereas there are only three days remaining for public scrutiny on Bill 26; and

Whereas public interest in this bill has been overwhelming; and

Whereas the vast majority of presenters to the standing committee on general government have recommended major changes be made to the bill;

I move that this committee recommend to the government House leader that the 68 individuals and groups that requested to appear before the standing committee on general government in Kitchener be given the opportunity today to see the government amendments to Bill 26.

Mr Chair, I'll try to take less than the minute you've allocated me. In light of the fact that the government is absolutely committed to proceeding on a timetable which sees us beginning clause-by-clause debate on Monday and voting on the bill the following Monday, it is absolutely untenable that here we are, three days to go, and we've haven't yet been presented with the full package of amendments to this bill.

I requested this of the Minister of Health the first day of hearings, December 18, in Toronto. I was informed by him then that we would get them in a timely fashion. I specifically requested that that be before we start the two weeks of travel on the road so the public could know what the amendments were, could comment on the amendments, and so the opposition had an opportunity to develop their amendments in light of the government's full intention of what it intended to present and to pass in the Legislature.

I understand today that we may have the first few amendments, and I applaud the government for finally getting us those first few, but I understand it will only be the first few and there will be more to come tomorrow and Friday, and maybe Saturday and Sunday and Monday morning, and then Monday we start to debate without having had any time for analysis. It's a repetition of the process we've undergone with this bill from the beginning and it is, as I said, untenable.

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Mr Clement: I cannot support the motion as read. But I appreciate and the Minister of Health, Jim Wilson, understands, where Ms Lankin is coming from, where the opposition is coming from, because we were in the same boat six short months ago.

I can assure the committee that the government is working as hard as it can to try to intake some of the public input that we've had over this process and respond to that input while still keeping the core of why we need this legislation in the first place: to restructure our health care system so we have the resources available within health care that are so necessary in the new and emerging areas of health care reform.

With that in mind, I would like to table at this time amendments the government would like to propose for Monday morning regarding schedule F of Bill 26. I herewith deliver these to the clerk for distribution. As Ms Lankin has mentioned, this a portion of what we intend to move as amendments. But as per Jim Wilson's and our commitment on the government side, we'll make them available as soon as we can, once we're comfortable that we have mirrored what we have heard as part of this very worthwhile public process. But I have to vote against the motion, because we're not quite ready to table all the amendments yet.

Mrs Caplan: I'll try to keep it to a minute, but I must admit I did get tremendously frustrated when I hear the government say that. The minister had acknowledged that there would be amendments coming. That was done the

day of his statement, the first day of these hearings, almost a month ago. The fact that they are just tabling a few of the amendments today tells me that their initial plan to have had this bill passed by Christmas was outrageous. The fact that the amendments are being tabled at the end of this process and the intention is that they will not be available in total in time for people to make representation to them is the best argument for extension of the public hearings.

Clearly, this bill is seriously flawed. We expect to see many amendments. I'm pleased that we are seeing some today so we will perhaps get an indication of where the government is heading. But it is inadequate to tell us that they're working on amendments; that we may not have them all before the end of the public hearings.

It also galls me to hear Mr Clement tell us how important this process is and that we know we're hearing new things every day and they're going to respond to that in amendments. If they'd extend the hearings, we know we would see additional amendments coming forward.

I will be supporting Ms Lankin's motion. It's important that we get those amendments in enough time for the public to be able to review them as well. I'm disappointed that the government has chosen to drag its feet, acknowledge how seriously flawed this bill is but not have the amendments.

The Chair: Thank you. We'll now have the vote.

Ms Lankin: Sorry, Mr Chair, just a quick wrapup. Holy mackerel—section F only, dealing with the amendments to the supervisors' powers in the hospital mergers and closures. I'm glad there's a lot of them, but I'm going to need some time to understand what these are. I suspect you all will, too. They're not really referenced in any way to Bill 26 in terms of where we find the parts being amended in Bill 26, which are amending parts of other bills. And this is just the first group of them.

The Chair: Is this relevant to the motion, Ms Lankin?

Ms Lankin: I think so. I think it speaks to the fact that it is going to take us considerable time to understand all the government's amendments to all aspects of the bill. To be in a position to deal with them on Monday, I urge you—I understand you're going to vote against this motion today—please get the rest of these amendments prepared to be tabled tomorrow, because we will not be in a position to adequately debate with full understanding if we don't have these and have the time at night for the rest of this week to go through them and understand what it is you're intending to do.

The Chair: I'm going to call for the vote. Those in favour of Ms Lankin's motion? Those opposed?

The motion is defeated.

RX PLUS INC

The Chair: We now call on our first presenter, representing Rx Plus Inc, Robert Morel, the president, and Charles Truax, the vice-president of information systems. Good morning, gentlemen. Welcome to our committee. I apologize for the delay. You've got a half-hour of our time. Questions would begin with the Liberals, should you allow time for them. The floor is yours.

Mr Robert Morel: Thank you for the opportunity to appear before the committee this morning. We certainly

feel somewhat privileged, given the number of people who would like to attend, and we do thank the three parties for giving us this opportunity this morning. My name is Bob Morel. I'm president of Rx Plus. With me is Charles Truax, vice-president of systems for Rx Plus. I'd indicate that the submission we are providing today is fully endorsed by the entire management team of Rx Plus. My comments today will focus specifically on the proposed amendments to the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act.

To give you a little background about our organization, Rx Plus was founded in 1974 and is a prescription benefit administrator responsible for the management of over 1,200 corporate prescription programs from coast to coast. Rx Plus clients, among others, include Honda Canada, Purolator, Navistar, Suncor, Wood Gundy, CanWest Global, the University of Toronto, McGill University, all the employees of the Toronto-Dominion Bank, to name just a few. In addition, Rx Plus administers a number of drug programs for 12 insurance companies.

We believe Rx Plus manages and maintains the largest national pharmacy network, with over 6,800 pharmacies, representing 98% of all the pharmacies across Canada. In addition, Rx Plus manages a prescription drug base of approximately \$750 million on an ongoing basis. Rx Plus systems are very sophisticated and have been designed to control ingredient price markups, professional fees charged by the pharmacist in each of the pharmacies, as well as any other markups that may be involved in the pricing of prescription drugs. The controls in place in the systems managed by Rx Plus allow Rx Plus clients to enjoy a net discounted saving of approximately 15% per prescription or, in other terms, approximately \$6 per prescription.

What we do is very similar to the Ontario drug benefit organization. You will notice a number of similarities today, in that ODB is responsible for managing a single drug program for approximately 2.4 million Ontario residents, while we are responsible for administering several hundred different kinds of drug programs for approximately 400,000 individuals across Canada. Not only can we bring experience with regard to what we have been doing in Ontario, but we also have the experience of what we are doing in each of the other nine provinces. Hopefully, that will prove helpful to you today.

Specifically, we wish to focus on four areas today: first, the elimination of the best available price, also known as BAP, and the deregulation of the price of medication in the private market; second, the introduction of copayments and deductibles; third, linking prescribing guidelines to reimbursement; and finally, a comparison between the public sector and what we have been doing in the private sector to achieve similar types of goals to those the government today is trying to accomplish and how they are somewhat different.

If I may begin with the elimination of BAP, best available price, and the deregulation of price in the private sector, in 1986 when the Liberal government introduced Bills 54 and 55, the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act, Rx Plus

supported the introduction of BAP for the government ODB plan in order to eliminate the practice of spread pricing.

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We also recommend at this time that the government not legislate the private sector. We remain consistent in our belief that the government should not intervene in the private sector since it is not the primary payer. Therefore, Rx Plus supports the change to the Prescription Drug Cost Regulation Act which will result in the deregulation of the price of pharmaceutical products in the private sector market. We would like to stress, however, contrary to reports by the press, that we believe, on behalf of our clients, that deregulation will not result in significant price increases on patented drugs for consumers. In fact, the competition in the free market should keep prices stable and may well result in decreases.

On behalf of our clients, Rx Plus has agreements with pharmacies that ensure that all three components of the prescription cost are controlled: the product ingredient costs, the allowed markups and the professional fee. This would not be affected by government deregulation.

In support of our position, we confirm that our clients' average prescription cost in the province of Ontario between January 1993 and December 1995—in other words, the last three years—increased on average only 4.9%. This is substantially different from the numbers we have heard recently, in the area of 16.4%. If we go back to 1986, when amendments were brought in, the government was incurring cost increases at the rate of 23% per year. We understand that this increase is lower than that experienced not only by the ministry here in Ontario but other ministries in other provinces.

Included in the above are pharmacists' professional fees, which range from \$1.99 to \$12.50. The range in pharmacy fees is based upon open competition, location, size of prescription and the total cost of the prescription.

With regard to the introduction of copayments and deductibles to the residents of Ontario, Rx Plus recognizes the fiscal pressures facing the Ministry of Health and the opportunity for the introduction of a copayment or deductible for recipients of the ODB program. We believe that any copayment/deductible must be structured in a way that will protect those who need the provincial plan the most.

Our many years of experience with hundreds of plans with deductibles and copayments indicate that caution must be exercised when implementing these measures. We'll give you some examples of what we're talking about.

(1) While the implementation of a \$2 deductible per prescription does not appear to have any impact on the drug utilization patterns, the implementation of annual deductibles even as small as \$20 single and \$40 family per year does impact on the utilization of prescription drug programs.

To prove our point, a May 1995 Compas study commissioned by Rx Plus relating to the 470,000-federal-employee benefit program indicated that 8% of the employees said they had instances over the last couple of years when they were not able to afford the purchase of their prescription drugs. These are individuals who are

well paid, yet 8% of them were not in a position, because of deductibles, to obtain their prescriptions.

(2) In the case where very large deductibles were implemented, such as those of the Saskatchewan government, we acknowledge that government disbursements have significantly decreased. More important, the main reason is a transfer of liability and payment to the patient. Large deductibles, in our opinion, discourage the appropriate and necessary use of prescription drugs.

We strongly believe that non-compliance associated with large deductible programs increases the cost to the other health care sectors, such as physicians' visits and hospital stays, thereby negating any potential saving. In a recent review of the literature of the University of Toronto, the economic costs of non-compliance were estimated at \$7 billion to \$9 billion.

(3) Linking prescription criteria to reimbursement: While increased consumer responsibility and accountability is critical for a more rational use of health care resources, the introduction of copayment deductibles in our opinion will not address abuses in overmedication. A 1994 Ministry of Health study entitled *Drug Programs: Framework for Reform* reports rates of inappropriate prescribing, utilization and non-compliance of 25% to 40% in Ontario. Each year in Ontario, 17,000 people are treated for prescription drug interactions, and one of out of every five seniors is admitted to hospital for the same reason. A recent study conducted by McGill University reached similar conclusions.

Rx Plus supports these studies and believes that inappropriate prescribing and utilization must be addressed. In light of these statistics, we understand the Ministry of Health's intentions behind the proposed changes to the Ontario Drug Benefit Act, which will permit the government to restrict payment for specific drugs to situations in which prescribed clinical criteria are met. However, we are concerned about how these guidelines will be developed and who will ultimately be responsible for their implementation and management. The development of guidelines or prescribing criteria must involve an open process which will permit the participation of all sector stakeholders who have expertise to contribute to the process. Specifically, therefore, these guidelines should be clinically based as opposed to being based on cost containment.

It is important to note that prescription drugs account for only 6% of Canada's \$71 billion in health care expenditures as compared to 47% for hospitals. Canada's growing aging population will continue to rely on innovative medications to improve their health and quality of life. Appropriate use of medications means reduced physician visits and hospital stays, better health care outcomes and improved cost savings to the overall health care system.

Just as an aside, we have to keep in mind that in terms of the overall costs the government is incurring at this time, there are things that can be done and there are things that can't be done. I can remember that in 1974 when the program was initially introduced, there were 700,000 members in the program. When we met again in 1986 the 700,000 members had increased to 1.3 million members. Here we are again 10 years later, again ad-

addressing the same issues, and we now have 2.4 million. Every 10 years, the number of participants is doubling. Is it any wonder that the costs are going up by 6.4%, as has recently been reported? Unless we are prepared to change the membership, those numbers will continue to increase, and as the average age of our population rises and the baby boomers continue to move through, we know from our database that utilization increases at the rate of 10% for each year the population ages, and there is nothing you can do about it.

Rx Plus believes that greater emphasis must be placed on the physician if the issues of inappropriate prescribing and utilization are to be addressed. However, we are concerned that the proposed change to the Ontario Drug Benefit Act which allows prescribing criteria to be linked to reimbursement may result in financial penalties to physicians which may supersede their professional judgement used when prescribing.

In addition, to be able to implement the kind of programs we're talking about to manage utilization and compliance, you need some very sophisticated systems. Those systems do not exist today. They do not exist within the government and they certainly do not exist with the gatekeeper, which is the pharmacist who sits at the other end of the telecommunication line. We know that the software that sits on the pharmacy prescribing counter cannot handle the kind of things we are talking about, because we were talking with them today about implementing programs that are not dissimilar and we are doing it on the basis of cooperating with the pharmacists. Because without their cooperation at the other end of the communication line, we can have the very best computer systems and the very best regulations and the very best ideas in terms of how things should be done, but someone at the other end who is talking to the patient, the cardholder, at the time the prescription is being dispensed—the pharmacist—is the one who will have to communicate whether this is appropriate for this particular individual.

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On that point, Rx Plus believes that pharmacists must not be penalized, but rather encouraged and empowered to work with prescription benefit managers like Rx Plus and the ODB to act in the best interests of the patient. We therefore encourage the Minister of Health to consult with the stakeholders in this process before implementing prescribing criteria and linking them to reimbursement.

Rx Plus believes the ministry should seriously consider meaningful partnerships between ODB, the private sector, the prescription benefit managers such as Rx Plus, the pharmacists, the physician and, most of all, the patient.

We support improved patient education. As an organization, I can tell you that within the next few days we will be announcing the implementation of disease management centres that are being fully funded by the pharmaceutical company Eli Lilly Canada, and we will be involved with the management of some of these clinical centres. They will manage diseases such as diabetes, which affects 6% of our population.

For these kinds of centres and the costs associated with them, we have been able to identify that for every \$1 invested in these education centres that are specific to

diseases, there is a \$7 return for each of those investments. I can also tell you that a number of major corporations have already signed up to participate in these new education centres, because it is new to Canada. They include, as an example, some of our large major financial institutions.

I'll just talk a little bit about the private sector and Rx Plus as an organization and how we perhaps differ from ODB. Through our technology, Rx Plus continues to monitor very closely over \$750 million of prescription drug claims in an online real-time environment. Our online real-time network allows us to develop new software applications which substantially increase our communication with our pharmacists. We recognize the important role the pharmacists play in our approach and endeavour to maximize their professional skills in serving our customers. Today, approximately 94% of all prescriptions that are received in our data centre located in Sudbury from pharmacies across Canada are received in an online real-time environment. That's 94%. So we have very sophisticated systems in that area.

We have also implemented new drug intervention programs which will provide greater quality of health care as well as economic value to our customers. In addition, we can design drug formularies specifically targeted to the characteristics of each of our individual clients. You can imagine that a drug program for the employees of Falconbridge Nickel Mines may be different than the drug program we would design for the employees of the Toronto Dominion Bank, because the employee populations are very different. These intervention programs for some of our clients have resulted in savings in excess of \$1 million per year without taking anything away from any of the employees.

Finally, Rx Plus is working with Eli Lilly Canada to launch disease management and education centres focused on the treatment and management of specific diseases such as diabetes. Our data clearly indicate that 20% of our employee population, of our cardholder population, which is 400,000, actually incurs 70% of all the prescription claims. Through improved disease management, patients will experience a better quality of life, which is our first goal, while effectively delivering lower cost to our plan sponsors, which is our second goal.

Rx Plus will welcome an opportunity to assist the Ministry of Health and this committee to use our private sector experience and expertise and provide further information on how these programs have adapted well to the private sector and how they may be adaptable to the public sector as well. We believe that our technology systems application and health care focus are best suited to deliver optimal health care outcomes to our cardholders, which is priority number one.

The Chair: Thank you very much, gentlemen. We've got a very short period of time for questions, two minutes per party, beginning with the Liberals.

Mrs Lyn McLeod (Leader of the Opposition): Let me begin by saying we certainly believe there are cost-savings to be made with good pharmacological management that involves professional pharmacists and physicians and patients. We have a number of concerns with Bill 26 and how the government's changes in drug

benefits may interfere with that. You've noted a couple of them in terms of whether or not prescribing guidelines will be clinically based. We've also heard concerns about how quickly government can respond to new clinical evidence and make changes to its guidelines.

You've also noted a concern about actual cost of copayment plans, which is rather ironical, to think this could be more costly for government. You've noted non-compliance. We've also heard concerns about increased volume in dispensing in order to save the dispensing fee and also cost of administration.

Let me turn to the area of deregulation, which seems totally inconsistent with the whole issue of pharmacological management in any event, and seems rather philosophical rather than related to the reduction of costs for government. You've said you believe deregulation will not result in significant price increases. In the course of our hearings we have heard so many different opinions on what will happen that I think no one, and I suggest least of all the government, knows what's actually going to happen with drug prices under deregulation.

London Life Insurance yesterday said clearly drug prices would increase; no question about that. The Ministry of Health has said that in the short term they'll increase. The CDA generic representatives said they couldn't get enough information to know whether drug prices would increase or not. I guess one thing that is clear is that it's going to lead to different drug prices, and I'd like your comments on what you think might happen in terms of differential drug prices. What would happen particularly in smaller communities? What evidence can you present for your belief that drug prices will decrease overall?

The Chair: Unfortunately, Mrs McLeod, you didn't leave any time for an answer.

Ms Lankin: I'm actually very interested in that question as well and have found it confusing, if not frustrating, that one day we'll have the brand-name pharmaceutical industry tell us that it will be okay, and the generics come forward the next day and say no, it won't. London Life says that in the long run they think competition will bring prices down, but the tools aren't there for parts of the industry to deal with helping competition. So I would like your comments on that.

Then one other quick point on user fees. I would say that my understanding of the majority of the increases that we've seen in the drug benefit program really has come from new drugs being brought on, and they're highly effective but they're new, high-priced drugs. It's not an increase of utilization per senior. There may be more seniors and more people coming on to the plan, but it's not more drugs per individual, and therefore the user fee actually will give the government a shot of revenue and bring their costs down to a new level, but the plan will continue to grow. It's not a cost-containment strategy, and therefore I think prescribing guidelines is more the way to go. I'd like you to comment on that too.

Mr Morel: I'm going to try to cover both a little bit, if I may. If we compare what we have been doing in terms of the private sector in terms of being able to control price, we have been able to meet with the pharmacy associations, we have been able to meet with the

pharmacy chains, we have been able to negotiate agreements in terms of negotiating prices that we believe are reasonable. There's no question that a single individual who goes into a pharmacy as a standalone consumer does not have any negotiating power, but certainly ODB has negotiating power and certainly an organization like ours has negotiating power, and we have the systems and the database to be able to negotiate very effectively.

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I mention in our brief that of our entire client database, our costs have only increased at the rate of 4.89% for each of the last three years. So we have been able to control the cost of the drug programs for our employees. If you talk to the insurance sector, however, where each individual pays for their prescription, then sends in the receipts after the fact, you will find that their costs have been increasing in the area of 14% to 15%, not dissimilar to the government sector.

In terms of pricing, I think we will see strong competition in terms of buying groups, in terms of the pharmacy chains, in terms of the independent pharmacists. We know that pharmacists here in Ontario own drug trading and they use drug trading as their main buying facility, so they do buy as a group, and we will continue to see ongoing development in that particular area.

Mr Wayne Wettlaufer (Kitchener): Thank you for appearing today. You say that 17,000 people were treated for drug interactions and that one out of five seniors was treated for the same reasons. Do you have any figures on how many were treated because pharmacists couldn't read the doctor's writing?

Mr Morel: Oh, my goodness.

Mr Wettlaufer: Okay, let's get on to something a little more serious. But there is an element to that.

Quite often seniors coming in to a pharmacist for a prescription are under a considerable amount of stress. The writing on the bottles is quite often too small for the seniors to read, and they quite often get the instructions from the pharmacist on how often to take the medication. Usually they forget because they're under stress at the time of getting the prescription filled. How often do you think that would be causing the drug interaction?

Mr Morel: I wouldn't want to venture a guess.

Mr Wettlaufer: I'm just pointing out—

The Chair: Thank you, Mr Wettlaufer. Thank you, gentlemen. I appreciate your attendance here today and your interest in our process. Have a good day.

ONTARIO HOSPITAL ASSOCIATION REGIONAL COUNCIL 4

The Chair: The next presenter is Al Collins, the CEO of the Grand River Hospital Corp. I understand he's presenting on behalf of OHA region 4. Good morning, sir, and welcome to our committee.

Mr Al Collins: Thank you, Mr Chairman. On behalf of OHA Regional Council 4 and the Grand River Hospital Corp, I'd like to extend my appreciation to you and the members of the standing committee on general government for allowing me the opportunity to appear today to present the region's views on Bill 26.

On December 18 in Toronto, the Ontario Hospital Association presented to your committee a provincial

hospital perspective on Bill 26. Regional council 4 was consulted during the preparation of the OHA submission and provided input. We are supportive of the OHA's submission to the standing committee on general government on Bill 26, most specifically that in its present form we cannot support those sections of the bill containing certain amendments to the Ministry of Health Act and the Public Hospitals Act.

In reviewing schedule F of Bill 26, OHA Regional Council 4 feels that as presently drafted the bill would certainly not support the principles or practices of voluntary trustee governance of the hospital system in our region of the province.

I would first like to provide a brief description of the hospitals represented within OHA region 4. To meet the diverse needs of its members and to strengthen the association's leadership and advocacy role, OHA member hospitals are organized into five regions representing north, east, southwestern, south-central and the greater Toronto area. Each area has a regional council which elects members to the OHA board of directors. The regional council structure provides the OHA with a network for regional consultation and advice.

Regional council 4 is composed of hospital members within the counties of Simcoe, Dufferin, Wellington, Waterloo, Halton, Hamilton-Wentworth, Brant, Haldimand-Norfolk and Niagara. Within OHA region 4, there are 14 small hospitals, 18 community hospitals, three chronic care facilities, two mental health facilities and three teaching hospitals, for a total of 40 hospitals.

As indicated earlier, we support the recommendations and concerns advanced by OHA in its December 18 presentation to the standing committee. However, in our presentation today we wish to provide a regional perspective on some of the concerns with the bill.

The proposed section 6 of the Public Hospitals Act provides the minister with new and sweeping powers. OHA region 4 agrees that government needs effective mechanisms to implement the restructuring reports being received by the minister from district health councils. We also welcome the announcement that the minister will be recommending sunseting the proposed Health Services Restructuring Commission. However, we feel that the following overriding powers vested in the minister under section 6 must also be sunsetted: specifically, those allowing the minister and his staff to direct that a hospital cease to operate as a public hospital; to direct the board of a hospital to provide or cease to provide specified services, or to increase or decrease the extent or volume of specified services; to direct the boards of two or more hospitals to take all necessary steps to amalgamate; to make any other direction related to a hospital; and to amend or revoke a direction.

Region 4 believes these powers are far too broad and sweeping and do not respect the principles of voluntary trustee governance and local community decision-making. However, we recognize that it will not be easy for institutions individually to cope with the major reduction in funding announced by the government in November. Ostensibly, Bill 26, according to the government, is about giving transfer payment partners the tools they need to

assist them in downsizing while still maintaining accessible, quality public services.

There are elements of this in Bill 26 and the economic statement; for example, guidelines for arbitrators, multi-year funding commitments, revisions to operating and capital plan processes, facilitation of access to other sources of revenue such as hospital crown foundations and copayments. These tools are welcome. But the section 6 amendments to the minister's powers are not tools for stakeholders but rather for the ministry. There should be no misunderstanding about that. They are in fact powerful controls, not simply tools.

Nevertheless, we are prepared to recognize that collectively, hospitals and government need to move expeditiously to ensure there is a rational and rapid restructuring of the hospital system in our region and elsewhere. Given the funding reduction of \$1.3 billion, we are prepared therefore to endorse the OHA's recommendation "that the time-limited provision for all of these powers in section 6 be four years, ending March 31, 1999. In this way, the statute will assist hospitals and the government in the restructuring of the hospital system, yet at the same time preserve the fundamental principle of voluntary governance for the future."

The government should endorse this reasonable amendment and approach. Mr Chairman, hospitals want to work with government, not for government. We believe this is hopefully the government's intent as well in the purposes of the Savings and Restructuring Act, as was set out in the explanatory notes to the bill. It says "to achieve fiscal savings and promote economic prosperity through public sector restructuring, streamlining and efficiency."

The appropriate relationships between hospitals and the provincial government should be restored after the restructuring commission finishes its work in the year 2000. This can only come about if the minister's absolute powers to control and manage the system are sunsetted at the same time as the commission completes its work. We note that in his opening statement to this committee on December 18, the minister said, "The Minister of Health will not be exercising these powers unilaterally," and that he expects the powers of the commission to "cease with the task."

If the minister does not intend to use the powers himself and the commission's mandate will expire in four years, why would the minister wish to continue to retain powers he says he doesn't intend to use? Logically, if the commission is terminated, the minister's powers should also be terminated. Otherwise, one has to assume that the acquisition of these powers is ultimately about something not tied to restructuring at all, but is related to something bigger and not yet disclosed to the public and this committee. If the new powers are merely something required to complete the restructuring of the system over the next four very tough years of restraint and downsizing, government should have no difficulty in embracing the OHA's suggested amendments for sunsetting the minister's extensive interventionist powers.

Local community-based solutions are preferable. There are many examples of such in our region. For instance, mergers have taken place recently, such as with Orange-

ville District Hospital and Shelburne District Hospital, which have amalgamated and are referred to as the Dufferin-Caledon Health Care Corp. Here in Kitchener, the Freeport Hospital and the Kitchener-Waterloo Hospital have merged and are now known as the Grand River Hospital Corp. A very recent announcement was that the boards of Chedoke-McMaster Hospital and Hamilton Civic Hospitals have agreed to work towards a merger. Also, in the spring of last year, the St Catharines General Hospital and Niagara-on-the-Lake General Hospital underwent an operational merger, resulting in a more appropriate alignment of operational programs overseen by one senior management structure. The region believes that plans for mergers and amalgamation developed voluntarily by hospitals and approved by district health councils should not require intrusion from the commission.

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Mergers within the region have taken place and others will take place because hospital boards and managers recognize that this is required and they are in fact prepared to act on it. The volunteer trustees of my hospitals and, I dare say, all hospitals within the region play a vital role in decision-making, and this should be respected.

The bill proposes that the powers of closure and amalgamation and any other matters related to a hospital may be delegated by the minister to any person or body. This approach removes the accountability for such major public interest decisions from elected representatives.

Region 4 members believe that elected officials must not be able to delegate these sweeping powers. The minister must make decisions on closures and amalgamations based on information provided by the most appropriate body and refer approved plans to the commission for implementation.

OHA region 4 supports the recommendation that the powers under subsections 6(1), that is, affecting hospital closures, 6(3), affecting hospital amalgamation, and 6(5), making any other direction related to a hospital, not be delegated.

The region has also outlined other concerns related to specific areas of the bill which I'll summarize briefly.

In the area of due process, region 4 hospitals feel that it's essential that part of the restructuring process, whether conducted by district health councils or other planning bodies, must include an opportunity for hospitals and the communities they serve to submit their views and to be heard.

With respect to the role of the supervisor, the region feels that given the powers of a supervisor are sweeping and could have great impact on the hospital, its board and potentially the hospital corporation, the appointment of a supervisor should not be undertaken without reasonable notice and an opportunity for the hospital to respond.

As there are limited details on the Health Services Restructuring Commission, hospitals in our area believe that, as a minimum, the membership on the commission should include appropriate representation of hospitals from the region who have successfully initiated and completed restructuring initiatives.

Relating to hospital bylaws, the provision for the regulation-making power of the government must be removed from the bill. The minister must not have the power to write hospital bylaws.

In relation to hospital funding, region 4 hospitals believe that the proposed amendments in Bill 26 would give the minister unrestricted powers in terms of imposing terms and conditions on hospital funding and that the unrestricted nature of these proposals would lead to micromanagement of hospitals, thereby imposing a degree of inflexibility in day-to-day operations.

In conclusion, region 4 would like to reiterate support for the Ontario Hospital Association recommendations presented in the December 18, 1995, submission to this committee. We concur with the OHA that, in its present form, we cannot support these sections of Bill 26 containing specific amendments to the Ministry of Health Act and the Public Hospitals Act, which I've emphasized today. There must be changes relating to the minister's powers, delegation of authority, due process, role of the supervisor, the Health Services Restructuring Commission, hospital bylaws and hospital funding.

As presently drafted, the bill would most certainly not support the principles or practices of voluntary trustee governance of the hospital system in Ontario, including the south-central region of the province. Thank you, Mr Chairman.

Ms Lankin: Well, thank you very much and I appreciate your presentation. While you were presenting I was flipping through pages here, looking at the old Public Hospitals Act, looking at schedule F of Bill 26 and the amendment to the old Public Hospitals Act and looking at the first of what I assume will be a raft of amendments that the government will be filing over the next number of days with respect to schedule F, which amends the old Public Hospitals Act. I'm trying to understand whether your concerns have been addressed or not. You might be pleased to know that some of the recommendations of the OHA in fact have been addressed and we can quickly identify those. If the minister is going to use his extraordinary powers to unilaterally close the hospitals, he's at least going to give you 30 days' notice so you have a chance to talk to him about it, I guess.

The powers to do that, which are the powers in section 6, which the hospitals have been concerned about, will also be sunsetted at four years along with the commission. So that's a positive thing, and we should say it's good the government was listening on that.

The powers in section 8, however, remain in terms of being able to appoint a supervisor at any time they want. However, again, if he's going to use that unilateral power he'll give you 14 days' notice of that so that the hospital at least does get notice that a supervisor is going to be appointed under these extraordinary powers. I would argue that the government's got to go back and take a serious look at that. It seems that if a supervisor's going to be appointed for purposes of closure or merger or whatever, that might be an appropriate way to go. But in any other circumstances all the due process protection that existed in terms of investigators, investigator reports, a response from the hospital, all that should be there. And

the extraordinary powers under section 8 should be sunsetted at the end of four years as well. That's not there.

They've taken out the bylaws provision, which you like, but it's pretty clear they still want you to file with the ministry. That's still there, so we've got to figure out what that means about your being able to implement your own bylaw changes. I obviously don't know the answer to that one.

There are some changes around the powers of revocations of doctors' privileges. It tightens it up a little bit, so that's some concern there.

However, let me tell you what they haven't listened to you on. The powers under subsections 6(1) and (5), closing, merging hospitals etc, it's very clear from the hospital sector that they want that power. If the minister's going to make unilateral decisions they want the minister accountable for it and not delegating it, and the delegation provision's still there.

Also, I think all of us have been talking about both the hospital restructuring commission's work should be tied to local DHC processes and your request that the minister's decision to close or amalgamate be tied to that. No reference to any of that. So there's still unilateral action on the part of the ministry not linked into any kind of local planning processes. Essentially, the government's still saying, "Trust us on that one."

With respect to all of the issues around micromanagement like the imposition of physician human resource plans and all of those sorts of things, they're all still there; none of that's gone.

That's a lot, I'm sure, for you to absorb because I just rattled through it, but it means that you've been heard partly. It means that you've made a whole presentation on a number of issues today that we appreciate getting but you perhaps didn't have to touch on. You could have spent more time on some of the other areas to convince the government of your argument, and it means you've got two days to get the rest of your colleagues who are coming before us to concentrate on the areas that are yet to be changed.

I provide you with that information because I think it's important that the public that's presenting knows that.

The areas that are left, the DHC-related areas, the sunseting of powers around supervisors, some of the due process protections, are those areas you would like to see us continue to push the government for amendments on?

Mr Collins: That's correct.

Mr Clement: Thank you very much for your presentation. As you know, about half an hour before you started your presentation the government did table its proposed amendments to schedule F to deal, I think substantively, with a number of the concerns that were raised by the Ontario Hospital Association by its member hospitals that presented to us and by individuals and other groups who made their views known. I feel quite confident that we have maintained the core tools necessary to change the hospital system for the better and reallocate those savings to other areas within the health care system, and have met some of the concerns that have been presented to us. For instance, section 6, which you spent a lot of time on, the so-called extraordinary powers to merge, close or amalga-

mate hospitals, has been sunsetted after four years. We have accepted that recommendation.

I would note that Ms Lankin made reference to the district health councils, and I would remind her yet again that section 8.1 of the Ministry of Health Act, which deals with district health councils and their ability to plan, to analyse and to advise, is still in effect and has not been touched by our legislation. I would note that under due process we have given the hospitals 30 days to respond if there is a merge, amalgamate or close decision that's been made, and I would note, with respect to the role of supervisor, as you have indicated, that that's an extraordinary power and we have given the hospital 14 days to respond before a supervisor is put in. I would note that a supervisor and his or her powers were present in the old legislation, so this is not a new power. We have changed the 30-day period under the old legislation to a 14-day period, and I acknowledge that that is a different day but I think it's reasonable under the circumstances. And we have heard with respect to hospital bylaws that the government and its bureaucracy should not be in the business of writing bylaws, that is, for the voluntary boards of the hospitals.

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I know that's a lot to put on you in a short period of time. I'm merely glad we were able to table them, as per both our intentions and opposition demands, as soon as we could. Do you feel we've at least gone part of the way to satisfy your individual concerns?

Mr Collins: I believe that the government, with the amendments you're talking about this morning, has gone part of the way. We still have concerns in the other areas I mentioned but I am pleased that we have been heard in those areas and I would hope that we would have somehow more opportunity to have dialogue with the government before the bill is actually implemented.

Mr Clement: I can assure you the dialogue will be continuing both before and after the bill is passed. It's our intention as a government to work with the hospital sector to achieve the savings and the sector that we need to have the hospital care that our citizens need, but also to reinvest the savings in other areas. So I want to assure you, if I can take my last 15 seconds, that will be an ongoing process and this is the start of the process, not the end of the process.

Mrs McLeod: I can't help but remark that it might not have taken the government quite so long to come up with such minimal amendments if it had consulted with the OHA before it brought in the bill.

Mr Clement: You're never satisfied, are you?

Mrs McLeod: Certainly not, and I would say to the government members that I can't take a lot of comfort from the sunset provisions, because my primary concern is with what's going to happen in the next four years. I say that because the government has made it very clear in bringing forward this bill—and it is a Minister of Finance bill—that this isn't about really giving powers to communities to make decisions for communities; this is about giving government the powers it needs to cut \$1.3 billion out of hospital budgets.

I worry about the unilateral powers of the minister to close hospitals, or to delegate those powers to another

individual or commission to close hospitals, when it comes in the context of needing to make that \$1.3 billion in cuts. I guess my concern is that over the course of the next four years, in fact over the course of the next six months, expediting the process is going to be a lot more about making those cuts than it is about what is in the best interests of the community.

In the context of that concern, I believe community processes can work. Sometimes they take longer than we'd like, but I think they can work, and this is an area, as you've noted, that demonstrates that in spades. Can you comment on what you think is needed as an incentive for community planning processes to work? I'm thinking in terms of some commitment of dollars back to the community so that the savings that are realized by restructuring are actually used to serve the health needs of people in your community.

Mr Collins: I think you've hit on a very important point, Mrs McLeod. I believe that most communities in the province that are going through restructuring processes agree that they need to be done, but where the restructuring results in some savings, perhaps, in the institutional sector, those savings should be retained by the community to be reallocated for provision of health services that are identified as needs by the citizens of the community. I think one of the greatest incentives that government could provide would be to allow at least some of the funds saved in restructuring to remain within communities for redistribution.

Mrs Caplan: I think an interesting point was raised this morning. I could understand the minister needing to have the power, where a hospital board en masse resigns, to be able to send someone in, but I'm trying to understand why he would need, or any minister would need, the power to eliminate a hospital board, given all of the other powers he has under this legislation, no access to court challenges on his decision. Why do you think they're putting that provision in, to be able to bring in a supervisor with 14 days' notice to a board?

Mr Collins: I think that's the point we are making in the presentation. We are concerned about that, Mrs Caplan, that the powers are far too sweeping. I think there are powers that are available to the minister under existing legislation—

Mrs Caplan: Absolutely.

Mr Collins: —that would permit this sort of thing, and we do have some real genuine concerns that these powers are far too broad, far too intrusive.

Mrs Caplan: Do you think individuals in communities will be reluctant to serve on hospital boards as volunteers, knowing that the ministry and the minister have these enormous powers to look over their shoulder and in fact come in and wipe out a board, without reason, I guess? You know, the public interest test is so broad and general. I would be very concerned about the reaction of the voluntary governance—the nature of our province—just given the attitude.

Mr Collins: That could be a concern. The voluntary governance has always been the backbone of the hospital system in Ontario, and I think that if people feel, as I mentioned, they are working for government rather than

with government, there will be less incentive to volunteer in the system. There's no question.

The Chair: Thank you, sir. We appreciate your presentation this morning.

UNITED STEELWORKERS OF AMERICA,
LOCAL 677

CANADIAN AUTO WORKERS, LOCAL 1451

The Chair: The next presenters are John Cunningham, president of United Steelworkers of America, and John Coleman, from the Canadian Auto Workers, Local 1451. Welcome, gentleman. The floor is yours.

Mr John Cunningham: Good morning. I'm John Cunningham. Mr Chairperson and committee members, thank you for the opportunity to present today. It's nice to see Minister Witmer out today. She doesn't make many public appearances in her own riding and her own constituents to face her own constituency. We are happy to share our time with John Coleman of Local 1451, CAW. My name is John Cunningham, as I said, Local 677, USWA.

Interjection.

Mr Cunningham: We'll give you the floor later, Elizabeth.

The Chair: Excuse me for a second, sir. I would like to hear what the gentleman has to say. I would appreciate it if we keep our conversations at the table to a minimum.

Mr Cunningham: We represent 900 workers in Kitchener manufacturing tires. Our local, in its 35-year history, has maintained a viable, flexible workforce with one strike of seven days' duration. This local's historical ability to negotiate has kept a thriving business in a community when most of the rubber industry has turned its back on Canada.

Schedule F, sections 5 and 6: Section 5 overrules the regulation on how provincial aid was granted. Now it has imposed terms and conditions and requirements of security for repayment. This is to be determined by the minister by what is called "deemed public interest." Section 6 gives power to the minister to close, amalgamate or specify services to be delivered. We have seen in the WCB system how the vague term "deeming" can be stretched beyond the believable.

Public interest in the past was determined by caucus, committee, standing committees, polls and consultation with professionals and experts in the field. The Legislature had to be hijacked—an act of piracy, some said—to get woefully inadequate hearings where hundreds all over the province still want to be heard. The government is jamming closure on many other bills, with ministers, let alone backbenchers, spewing little information but much rhetoric. Few are reassured of the nebulous phraseology of "in the public interest" in the hands of a government that refuses to listen to its own people.

Subsection 8(1): We see "or any other matter relating to the hospitals where the Lieutenant Governor in Council considers it in the public interest" as a catch-all that allows a grab at the unknown.

Section 9 gives powers to an appointed supervisor to completely take over a board of directors or corporation where previously the board only had the obligation to

follow the supervisor's advice. It was presumed in the past that if a board ignored the super's advice, the press coverage and public opinion as well as the minister would move a board to act upon the recommendations of the supervisor. Now we see a continuing spread of the oligarchy as the supervisor reports to and follows only the directions of the minister.

Clause 9.1(1)(d) gives room for contract raiding tools in finally stating what public interest overrides are, "the availability of financial resources for the management of the health care system and for the delivery of health care services." If cutting taxes, the availability will surely be strained beyond belief.

This and others, in section 13, deliver the final stroke contained also in all other places in Bill 26, that the minister and the cabinet are protected from any legal liability and without accountability from decisions as a result of their direction. Most people or institutions that act without regard to any legal liability are considered criminals or kings. This government would act above the people and set itself above the laws by not making itself liable for its own actions. Instead of the word "protected," the term should have been "irreproachably absolved," as we see protection built into section after section, act after act.

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Independent Health Facilities Act: It would appear again that an all-powerful minister can take the redefined "facility fee" and allow independent health facilities to charge over and above the prescribed regulation. The definition of an independent facility is expanded at the minister's pleasure, and the direction points to the end of the tendering process, moving away from the Canadian-owned, non-profit facilities towards the two-tiered US system.

Schedule G: The danger is that deregulated drug prices, which was not in the Common Sense Revolution, with patent protection provided in C-91 installed by the federal government, will escalate through the roof. Ontario is the only province without drug price controls. This bill gives the cabinet unfettered power to enact regulations setting user fees which are a marked difference from those announced by the minister.

The cause of escalating costs for the Ontario drug program is the high cost of drugs covered by patent protection, overmedication and overprescribing, not abuse by users of the system. We are told that deregulated drugs will go down in price. Boy, is that believable. I can see myself haggling with some pharmacist over some penicillin for my children like a can of tuna. The last group, or the group before, also reported that prices rose 4.5% last year.

Cabinet will also assume the powers to determine which drugs will be listed as well as their cost. This was done in the past by a drug formulary committee. As a local, we have had no increase in benefits since 1992, fighting off lifetime caps, yearly caps and reduction of benefits, only to have the government pull the rug out.

In the termination of the Ontario Pharmacists' Association bargaining rights and the government's power to overrule physicians on appropriate medication, the reading of these two additional gatherings of power is as

draconian as it sounds, replacing sound professional advice and knowledge from the bodies that did deliver those services and placing them in the swollen hands of the cabinet and minister.

The release of confidential medical information is what this government found abhorrent when on the other side of the House and hooted and hollered and hounded the government of the day for months. In society today, we all must sign away the ability to check the validity of claims we make for illness or accident insurance. We must sign and allow full disclosure to justify our claims. We expect that the minimum of professionals will view the claim, if the information is needed only. To know that government officials could view anyone's file is a gross misuse of power.

Reversals of court decisions is a recurring theme, that this government must wipe out anything that is not in its image, that court officials must all be card-carrying NDP. In one of its decisions, the court ruled that the government failed to comply with the orders, that the government must faithfully discharge its obligations under the law. The government is being a sore loser and now seeks to nullify those decisions by legislation. Acting as a banana republic and showing contempt for the law is opening the province for business conglomerates, not for business.

Schedule H: Bill 26 removes all references to medically necessary services and gives broad powers to cabinet to decide those services to be insured and under what conditions or limitations by the future regs.

With the slant at the WCB that repetitive strain and lower-back injuries are not real or compensable in the future—at least that is the contemplation—what a saving to lend the same definition to non-workplace illness in determining if those services are medically or therapeutically necessary.

Throughout Bill 26, fees payable pops up, tools to raid or open up contracts appear and new powers are accumulated, the right to be untouchable and above the law for newly created laws and to repeal old laws and court decisions. While spending tens of thousand more on fees payable, and while being the new Ontario poor—and growing poorer—class, to have fewer and fewer benefits and pay more and more for services while telling us that you will save a few thousand over several years on tax rebates does not balance. Most Ontarians share the value of great caring for each other. The majority of Ontarians know you must pay for a just society. Most Ontarians want to be assured that the moneys they are taxed are paying for the services they want.

The common non-sense election document promised a fully funded health care system and, "Under this plan, there will no new user fees." The document said you looked at delisting, user fees and copayments, "but decided the most effective and fair method was to give the public and health professionals alike a true and full accounting of the costs of health care, and ask individuals to pay a fair share of those costs, based on income."

These hearings became a reality only after the rightful sit-in of the Legislature. You have hijacked due process. You would have jammed the bill through without one day of hearings. The amount of people who want to respond

to your revolution would indicate that poor Alvin Curling should have held out for a month so that the people of Ontario could have been heard.

Don't drag out that tired rhetoric that this is what you promised in your campaign, as you did not promise this at all. Every day people who supported you are phoning us in fear and panic asking what to do, where to protest and where to go to be counted as opposed. In the spring, the sleeping giant of the uninformed electorate shall arise. Even doctors are practising the form of protest that only money can buy, this very day, in radio, TV and newspaper spots against Bill 26. Whether you call me a socialist or we call you fascist has little bearing. It will be you who have lost the respect and support of the people of Ontario, just as you have federally.

Mr John Coleman: John Coleman, president of CAW Local 1451, representing some 1,500 members at Budd Canada. Obviously, my presentation was written—I'm not aware of the amendments that have gone through. However, in general, our so-called difference in philosophies, as I'm told by the government in power today—ours obviously is we have some concerns. I want to reiterate basically what John said. I'm not covering as large an area as John, but I would like to certainly key in on some critical areas that we have a major concern with.

Bill 26 is systematically moving our health services towards a two-tier system. The thrust is towards user fees and extra-billing as means of reducing costs. There is nothing in this bill that would indicate that the government's intent is to improve services to its clients, the people of Ontario. Like everything else that this government has undertaken, the only priority is to cut spending, no matter what the consequences are to those who are less fortunate than some of us.

It becomes obvious as we familiarize ourselves with the contents of Bill 26 that one of the government's major objectives is to gradually move more of our medical services over to the private sector. The for-profit, private sector's natural goal is to maximize its bottom line. Therefore, it is very likely that services will be sacrificed for profit.

I wish to share the experience of one of my parents, who live in England, which has adopted a two-tier health care system. Both of my parents pay for additional private health care. My mother fell and injured her knee. This was in the late afternoon. She was taken to the private hospital, expecting to receive the attention she had paid for through her additional premiums. When she arrived she was told that they had no doctors on duty, only nurses at that time. There were no doctors to make the necessary examination, diagnosis and administer the appropriate medical procedures. She would have to attend a public hospital that provided 24-hour doctor services. When she inquired as to why the private, for-profit facility did not have the appropriate medical staff available, she was told that if they were to maintain 24-hour medical staff, costs would increase significantly and they would have to substantially increase client fees. They added that from their experience, there was not a great enough need during the evening and early morning hours for doctors' services.

The lesson I believe is clear: When it comes to health care, private, for-profit facilities do not deliver the services that a public sector hospital would and should provide. As in the case with my mother, private sector health care facilities will cash in on the use of public sector hospitals to provide the services when they cannot because of their concern with the bottom line.

One only has to observe our neighbours across the border in the US and their health care system. Because they depend on private sector hospitals and they have to provide all of their services 24 hours a day, seven days a week, the cost of medical care is phenomenal. As more and more medical services are contracted out to the private sector, it will only be a matter of time before we end up with a two-tier health care system in Ontario, and eventually in Canada. That's sad.

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Schedule F of the omnibus bill: Health service restructuring amendments give enormous powers to the minister and cabinet. It removes the previous powers of the district health councils whereby the communities had at least some influence. The new hospitals restructuring commission could diminish this opportunity considerably. I do understand some of that's been changed. I still don't think it's far enough, but some of it has been changed.

Bill 26 takes away the independence of hospitals and the communities they are located in. The possibility that a hospital can be closed at the stroke of a pen—and I believe this now has been changed—by one individual is unbelievable.

Ms Lankin: They can still do it.

Mr Coleman: They can still? Oh, okay. They just give 30 days' notice. Is that right?

Ms Lankin: Yes.

Mr Coleman: Okay. It is all very well to scoff and say that this will not happen; the fact is that it could happen. And there are no safeguards to make sure that this does not happen. There are also no procedures to allow people within the communities affected to have an opportunity to prevent the closure. References are made to the minister's authority to decide funding based on a hospital's quality of management, quality care and treatment of patients and proper management of the health care system. It sounds reasonable until you come across this statement: that funding is also decided on "the availability of financial resources for the management"—and the delivery—"of the health care system." Once again the priority is costs, not the delivery and quality of services. The omnibus bill gives the minister the power to virtually dictate any aspect of the operation of a public hospital. When the only objective is to reduce costs, this kind of power is frightening.

I wish to close by emphasizing, as I did last time when we spoke in general on Bill 26, that the most shocking theme throughout Bill 26 is the extraordinary decision-making power put in the hands of a few, with no virtually no avenue to appeal or protest those decisions. In fact, in the majority of situations, those decision-makers are protected from any accountability through various amendments to those acts that have been addressed.

I thank you for this opportunity to give our opinion.

Mrs Janet Ecker (Durham West): Thank you for coming forward with your views. While there may be differences in philosophy between some of the organizations that have come before us and some of the members who are sitting at these tables, that's the purpose of the hearings, and I'd like to thank you for bringing forward your views.

You make the point that only the private sector would be paying attention to the bottom line. I would submit that the public sector hospitals have had to pay attention to the bottom line for many years now, and that's one of the reasons we've closed 9,000 beds in Ontario—because of problems with affordability.

One of the things about the Independent Health Facilities Act is that it's about quality, and Mrs Caplan likes to talk about that. Her government brought it in and it's an excellent piece of legislation which promotes quality assurance in facilities. One of the difficulties is, if as part of a role change that a hospital goes through as part of the local planning process, which is something that this government supports, that a hospital were to wish to change its role into an ambulatory clinic of some kind and become an independent health facility, regulated and licensed under that, do you believe that we should force that hospital to go through a complete RFP?

Mr Cunningham: To tell you the truth, other than the comments that we made—I mean, you've had a greater opportunity to examine and make those observations or draw your conclusions. I finished my presentation a scant 10 minutes before driving down here. So do I believe health care needs revision and/or observation as to its operation? Any institution needs that in a continuum in today's society. But the manner in which you do it can be destructive, and I believe that the manner you have set out can and will be destructive.

Mrs Ecker: Okay, but do you not appreciate the point that we need to have further quality provisions within the health care system, which is what the Independent Health Facilities Act and extending that to other facilities is all about? So that regardless of ownership, profit or non-profit—and there are for-profit clinics now in the system—those quality mechanisms remain the same. To me personally, anyway, that strikes me as being a positive thing for the system.

Mr Coleman: A positive thing for the system, but I still want to emphasize the fact that your government still only looks at the costs. I'm saying there is a line drawn where quality can be affected because of the costs.

Mrs Ecker: How do we continue to provide health care when we're using borrowed money to do it?

Mr Coleman: We can discuss that, but that's a different issue. We have other ways—

Ms Lankin: How do you give a tax cut?

Mrs Caplan: Yes, use your tax cut.

Mr Coleman: That's right, and we said that last time. I don't think you were here, Janet, but that was what we said. You want to use that tax cut. Use that tax cut and look at tax reform too, because there are other areas that you can be looking at where corporations have a far greater advantage than the average taxpayer.

Mr Bruce Crozier (Essex South): Thank you, gentlemen, for two comprehensive submissions. You represent

labour, of course, as many labour groups have come before us, and we're still to hear from others. I must warn you, though, that according to some information that was circulated in Windsor on Monday and that we are told continues to be sent to interested Ontarians, you are a vested interest and this government looks upon you as a vested interest, notwithstanding the fact that you have the democratic right to represent your workers.

In the line of representing workers, I wanted to ask a question, again, that appears on the information that the government is circulating. These aren't my words, by the way; I don't know whose words they are. But it says, under the "Reality Check," that a myth is that "Bill 26 caps pay equity payouts to 100,000 of the lowest-paid women in this province." As they say, the reality is, "There is no cap," and that may be the case, but "Bill 26 only changes how pay equity is achieved." As you're well aware, one way that "how" is arrived at is that there's no longer the proxy system.

So I wonder, in your representation of labour—and I certainly don't consider you a vested interest; you have a legitimate interest—how that part of this bill affects the 100,000 lowest-paid women in this province and what you think of that.

Mr Cunningham: That was last week's topic, but we'll be happy to answer it.

Mr Crozier: Well, there are many low-paid women in the health care field.

Mr Cunningham: We also hope that vested interests stay within our pension and some of those pension vehicles that seem to be questioned within the public service remain for any schedule of payment. It's obvious that those things were set out to relieve the lowest members of the health care industry. That they are female is coincidental and that we should strive to raise those people above their sufferings is apparent. It goes with contract rating and the ever overused "tools." How do I possibly answer your question unless we've got about seven days or more?

Mr Crozier: It's interesting, and I agree with you that we should have more than seven days. You referred to that earlier, that there have been various descriptions of how our methods used to obtain what hearings we have were arrived at. In fact, as you probably well know, I was one of them who felt my rights were being restricted when I was locked up in a room when this bill was introduced.

Ms Lankin: There were a number of opposition members in that situation. I think that the concerns of how the bill is being handled continue as we see ourselves closing in on the end of public hearings. While I appreciate receiving the first few amendments today, every day we'll be seeing more amendments. I assume this weekend we'll be going through rafts of paper like this, trying to make sense of it, without an opportunity for informed debate.

I want to ask you a question that's very different than your presentation. I understand the points you make about the bill. Particularly, John, you were talking about a two-tier system and what comes out of that. But both of you represent workers that work in major industries, and I'm going to pick one. I'm going to talk about the auto

industry, because you would have auto parts and be contributing to auto parts in both of your memberships.

My experience in dealing with auto manufacturers, the Big Three in Canada in particular, and all of the component parts companies that go into it, is that their major competitiveness right now is in the cost of their car and its comparativeness to the United States, and the biggest reason for that is the cost of health care. The cost per employee for health care benefits in the United States in a two-tier system where the employer starts to pick up, through negotiations with your colleague unions in the US, is \$4,000 per annum, the average cost in large industry. The average cost in large industry here, in the Big Three let's say, for those Canadian employers is \$700. That is a huge difference in the cost per car.

This government, while they may be ideologically interested in a two-tier system, should understand the competitiveness factor. Could you comment on that from the perspective of your employees and what you know about the huge increase in investment in the auto sector in Ontario and what that means to our economy?

Mr Coleman: I can tell you that probably some of those plants and those factories would not be in Ontario, despite the competitiveness, the rhetoric that you keep putting across, they wouldn't be here if it wasn't probably for the lower costs of medicare in Ontario and in Canada in general. Obviously Ontario is a good location for their assembly plants in the US. But everything we produce in Canada goes into the US.

Of course the Canadian dollar has got something to do with it too. There's no question of that. That's part of it. But also, as Frances was pointing out, the lower costs in medical care are definitely a factor.

I don't know where you would want to go or where we would be if you ended up with a similar system to the US, and if we start going with a two-tier system, eventually that's where we will end up. I just don't understand the ideology behind that, I really don't. I'd like someone to explain that to me. You may not have time today, but some day, somewhere maybe you, Elizabeth, can spend some time with us and explain to us that philosophy or that ideology.

The Chair: Thank you very much, gentlemen. We appreciate your appearance here today, your interest in our process. Have a good day.

Out of necessity, we're going to have to have a quick two-minute recess.

The committee recessed from 1033 to 1036.

KITCHENER-WATERLOO ASSOCIATION FOR COMMUNITY LIVING

The Chair: Okay, folks, we'll get back to business. Our next presenter is Jack Scott from the Kitchener-Waterloo Association for Community Living. I see that Jack is joined by Deborah Moskal. Welcome to our committee.

Mr Jack Scott: Ladies and gentlemen, I am Jack Scott. I am the community worker with the Kitchener-Waterloo Association for Community Living. I will be introducing our presentation and I'll be followed by Deborah Moskal.

This is a response to Bill 26 by the K-W Association for Community Living. The association is a voluntary, non-profit organization run by families and individuals who work on behalf of those with developmental challenges, for example, mental retardation. We do support, advocacy, education and community development work with individuals, families and the community at large.

Our vision of the association is that of a community that is aware, accepting, compassionate and tolerant so that people who are developmentally challenged and their families have access to opportunities, supports, rights and services which enable them to participate as fully integrated members of the community. Our mission statement says that people with developmental challenges are included equally in all aspects of community living according to their choice.

Behind our vision and our mission we have some very significant values. Our focus is on person-centred supports in the community. Because we believe citizenship is the right of every person, we strongly value the whole person. We recognize the need to support different options for different people. We also have an openness to diversity. Because we value listening to different points of view, we respect that people and their ideas are limitless.

Our stand in this presentation: We feel that the government's approach in this consultation process is contrary to our basic belief in community inclusion for people with developmental challenges.

We are having difficulty speaking to many of the specifics of different sections of Bill 26. First, we are going to address the broad impact of your approach to implementing these changes in the health field.

The government's consultation process is non-consultation. Its attempts to rush Bill 26 through so quickly destroys consultation. The government has given only three weeks for consultation with the whole province, and very little preparation time has been given. This is inadequate, and for our community of people with developmental challenges it is particularly significant.

Generally speaking, we find that the community at large is not very knowledgeable about the potentials and needs of people with developmental challenges. It is our community of individuals with developmental challenges and their families who are the most expert and knowledgeable. To make sure that the best policies and decisions are made, we must be consulted effectively. Effective consultation would allow more reasonable time to prepare and to respond. History has shown that where the wrong decisions have been made with our group, excessive waste and cost have been incurred.

The Association for Community Living supports the closing of the large institutions that have proliferated around our province and country over past decades to house people who were developmentally challenged, but the current program of deinstitutionalization is a significant example of this wrong decision-making process. Along with this closing of institutions has been the movement towards living in the community that has accelerated in the past decade.

Our association supports the direction of closing institutions, which have been an inadequate and costly

way of life for any citizen, but we do not support the government's policy of eroding community supports at this time when they are most needed. Living in an inclusive community is a more appropriate way of life, more cost-effective, if it is done correctly and with the right supports.

Because of their significant handicaps, people with developmental challenges must have appropriate supports in order to be able to realize their potential. Otherwise they could be a drain on our economy and society instead of being able to be contributing members. But it is we in the community who best know how these supports must be built in and we must be consulted effectively, not in the government's rushed way.

Our families are overburdened. They have many extra stresses related to the severity of the handicaps of their family members. These stresses will not go away because the handicaps usually cannot be cured. They must be understood and included in the social and economic fabric of our society. But also our families are an average cross-section of our society. They are the same as you and I.

In our association of families and individuals there is the potential for the highest levels of leadership. Through our adversities we have developed significant strengths. We can help save our society in its present crisis, if the government will only listen to us more. Instead it is cutting services blindly, taking away our community voice, dividing us by forcing us to take action in so many different directions to save our services and making us powerless over the directions of our lives.

The government has told us that people with developmental challenges are one of their priorities, that no more cuts will be made in this sector. But we understand that significant cuts will be made to drug benefits through user fees. People with developmental challenges often rely on medications for their various medical conditions, such as seizures. The spinoff impact of this decision has not been looked into well enough.

Our Association for Community Living works most effectively in support of people who have developmental challenges when we follow a path of empowerment, people having control over the direction of their own lives. In the government's Bill 26, this power is now effectively taken away from all of us when our ability to appeal any of your decisions, any of the government's decisions, is taken away through the government's "immunity from liability." This is written all through the bill. No one can question, sue, charge, appeal etc. We must trust that the government is "acting in the best interests," "in good faith." We ask you to trust us too, that we are acting in the best interests and in good faith.

The government has the power to make choices, to decide on what process to follow in its consultations. We ask the government to please make the right choices for our sakes and for theirs. The government can weaken our valid input, reduce our power over our lives, prevent this group of people who have developmental challenges from having equal citizenship; or the government can seek our input effectively, empower us so that we can gain strength through feeling more in control of our destiny

and support our mission of equality in all aspects of community living. The choice belongs to the government.

We are asking the government to moderate its stand over privatization, centralization and broad, deep cuts in the social services. They are destroying our social fabric, which we do not want to lose. Share your concerns about our economic plight more with us. We have the same concerns. Keep us as equal partners in a positive process of community consultation. Do not isolate and polarize us by restricting communication. The social costs will backfire on the government as well as on all of us because its efforts to solve our plight will have less chance to succeed. Even as we are speaking now, there are frightening signs that we're slipping back into a recession. We must learn to work together more effectively to save this.

Go slower; listen more; be more compassionate; work together with us.

Ms Deborah Moskal: What I'm going to say is not written down. That's because I simply have not had the time to process what I was going to say as well as write it down at the same time.

We also had hoped that a self-advocate would be able to come and speak to you as well, but because of the time that we were given to organize this, we were unable to get one who was willing to give up their time at work or able to give up their time at work to come and speak with you.

I grew up as a middle-class person in Kitchener-Waterloo and I remained that way until 1983, when my son, at three weeks of age, had a massive stroke. At that time we went into the hospital here and then into the hospital in Toronto and we received excellent care. Within a month my son was diagnosed and received treatment. We came home and we continued to get treatment and we continued to get services so that he could develop to the point where he was well past what had been expected due to the damage from the stroke. The complete damage ended up being one entire hemisphere and the frontal lobe of the other hemisphere.

At that time he was expected to be profoundly retarded, blind, deaf, just to lie there and do absolutely nothing, but because of the care that we received at that time he was able to progress. Right now he's in grade 7. He's behind significantly, but he is counting and speaking and seeing and doing and he is living a full life.

He has many medical difficulties, and we do use the health care system a fair bit. We would probably be considered by the Mike Harris government as a drain on society. I always worked until 1990. I was employed by a private company which decided to do some restructuring and I was one of the people who was restructured out.

At that time I totally lost my mind. I didn't know what to do and, being a single mom, I needed to go on social assistance and that was probably the worst thing that happened to me in my entire life. But my son needed me and I had no job, so I went back to school and I have been upgrading my education in this time.

Unfortunately, the care of my son has taken a toll on myself and I have actually been, as I'm sitting here today for the last two days, in extreme pain due to a back

condition that I have that's exacerbated by the fact that my son does not walk and that I need to carry him and transfer him. But I'm not complaining; what I am is afraid. I'm afraid that my son will not have choices or that we will not have choices for medical care for my son, that he will not be able to get the exemplary medical care that he has received in the past.

1050

I'm afraid that I will not be able to care for my son because of my medical problems, because I will not be able to get the medical care I will require as my condition progresses. Presently I'm seeing a chiropractor every two weeks. OHIP pays a certain amount of that, not the whole amount, and that is certainly a help to me and enables me to continue. If I were unable to do this, then I probably would be in a wheelchair myself and be unable to care for my son at home.

I don't see anything about that in the act, but I do see a power in the act that allows the government to do what it wants to almost anything that is in relation to the health care system. That is our fear: losing the ability to have choices, being dictated to, what we can do, what we can't do, having no power. Right now we are a population of people who have very little power. We are very reliant on services, we're very reliant on professionals, and many of those professionals are very intimidating to our families.

We feel that we have no choices, but if this act goes through as it is written we will have no choices. That will impress us more and that will put us into deeper poverty than we're already in. I would not have the opportunity to go back to school and work. As of April I will be finished my courses. I will be working and I will be able to support my son. But many people will not have that opportunity if their choices are taken away and if they're being oppressed more and they become depressed and they feel bad about themselves.

I have a fear about the medical records being opened up. I don't know what's going to happen to me if my medical records and my son's medical records are opened up. Raising a child with a disability that's as extensive as my son's is a very difficult thing. Sometimes we have feelings of anger; sometimes we have feelings of frustration. These things we're able to speak to our doctors or our social workers about without fear of other people judging us based on our feelings, and we're allowed to feel that way. I have no idea—either I won't be able to speak to people and get any sort of support that I need or I will live in fear of my child being taken away from me because I'm having feelings that someone else might not feel are normal or acceptable because they're not living in my shoes and they're not doing the things that I'm doing and they're not understanding what we do as a population.

We have people, as Jack had mentioned, who are living on a shoestring. Adults with developmental disabilities who are either living in residence or are living in the community in supported independent living situations have very little money. Those people who are regulated under the Homes for Retarded Persons Act—which is very archaic—are living on a \$118-a-month comfort allowance. That comfort allowance is used to buy sundries, clothes, vacations. Some of the people who have

greater needs, such as using Depen, need to spend some of that money to purchase Depen, and now they're going to have to use \$2 per prescription to buy their prescription. What will probably happen in some cases is that they will not do without prescriptions; the money will come out of agencies which are already strapped and that money will be taken out of somewhere else.

People who are living in supported independent living situations are living in rent geared to income but they are paying for transportation, they are paying for food, telephones, cable, all the necessities of life, and they have very little money based on the pension that they make. Many of them, as Jack indicated, are able to live in the community only because they take prescription drugs that allow them not to have to be in a health care facility. They may not choose to buy those drugs and they may not then be able to remain in the community, or they will have to not eat or do other such things that may not be acceptable to them. Their socialization, their recreation right now are limited.

If user fees are charged, then these people will not be able to access recreational—and I'm speaking of the user fees that will probably be imposed by the municipalities when they're given the power to do so. That may not seem like a health issue, but it is, because people then become isolated and they then become depressed and they then are unable to live their lives to the fullest. If you look at health in its truest form, which would be whole-life experiences and what impacts on your health, then there are so many things that can impact that we can't even touch upon them.

I guess one of the biggest things is the fact that we just don't know the impact of this. We're afraid of losing any sort of power, any sort of say. Again, there has been no consultation. When my son was having some difficulty with his eye, when he developed an inflammatory condition in his eye, we went to a doctor at Sick Kids in Toronto and I started asking him questions. He told me that he had no answers and that I just needed to go to the library and look up the readings of a doctor from Cambridge, England, to learn about my son's condition. I was able at that time to switch doctors. Can you say that will be able to happen in the future? I don't think so.

I'm afraid that we won't have the health care, that we won't have the ability to live as truly equal and functioning citizens in this community. We will become more impoverished and, again, lose hope and be a drain on society. We will be undesirable. In the older days, not too long ago, people with developmental disabilities were put into institutions. Will those decisions be made by the government again, that our children will need to go into institutions?

We have a fear that this particular bill opens up the possibilities for anything and we want people to know that our children are fully functioning individuals. They have personalities, they are people and they do have needs, they do have wishes, they do have goals and they do have dreams. We want them to be able to live in a community, in a province, in a country that respects that, respects them as citizens and believes they can contribute and that they can be asked for their input and live a full life.

Mrs McLeod: Thank you very much for your joint presentation. Yesterday in London we heard a very passionate presentation from two self-advocacy groups for the disabled. They put a real face of fear and helplessness to this bill because nobody does know what it's going to do, and you've added to that in a very meaningful way.

There are a lot of aspects of your presentation that I'd like to ask you about a little bit more. Maybe I'll pick up on the issue of the changes to the drug benefit plan, the introduction of copayment. You've spoken to the \$2 and the effect that can have on those who are on a disability allowance and they have \$118-a-month comfort allowance with that. Could I ask whether or not all of the families or individuals that KWACL is working with are on a drug benefit plan or whether there would be families and individuals who pay their own cost of drugs?

Ms Moskal: I believe there would be families paying their own costs, but I believe that would be minimal.
1100

Ms Marilyn Churley (Riverdale): Thank you for your presentation. It helps all of us, I guess in particular the government members, who have the power to bring these new laws forward, to hear individuals like yourself who have struggled so hard and successfully to raise your own child and I think seeing real people struggling and making their lives better despite all the obstacles you face is very, very important.

This government has already, before this bill, made changes that have hurt the disabled in terms of redefinition of disabled. Some people in my area, Toronto for instance, their kids have lost their transportation; therefore people have had to quit their jobs or will have to quit their jobs because their kids no longer get the transportation and it would spiral downwards. Welfare cuts have in fact hurt some disabled. There are already problems there, so I understand the fear that there's more to come.

It's interesting that you brought up the drug problem because in fact that's what I was going to ask you about. In Toronto right now, we have people freezing to death already this winter. There are more families in motels who are homeless. It's shocking what's happening and we haven't heard from this government yet. We have to ask, where is Mike Harris and where is this government? We haven't heard a statement or comment or anything about what they're going to do. People are freezing in the streets. We're afraid there are going to be more deaths.

So my question is, coming back again, you stated your fears very, very well and the disabled community has those fears. The issue you mentioned about drugs is one of importance because I know already—

The Chair: Unfortunately, Mrs Churley, your two minutes are up.

Ms Churley: Thank you for raising that and I hope that the government will consider trying to support people with those problems.

Hon Elizabeth Witmer (Minister of Labour): I'd like to express my sincere appreciation to both of you. I know the hardship that you have tried to overcome to raise your son and I respect you for it. I guess I'm personally very concerned to hear you say that you face continued uncertainty. I know that this has been ongoing now for

several years as governments have made changes. There's been the discharge of people from the institutions and we seem to have not been able to do a very good job of providing the support at the community level. I guess I'd like to ask you, how can we somehow give you some comfort and degree of certainty? What do we need to do that's going to help you?

Mrs Caplan: Scrap the bill.

Ms Moskal: I don't know if I can answer that just in a nutshell. First of all, Jack has said very clearly that you need to talk to us and find out what we want, and we recognize that you have spoken to us, not in terms of this bill but in terms of other situations. You have to change the bill so that it does not give the government altruistic power to make unilateral decisions without consulting the community and without considering—well, without consulting the community and the people it impacts on.

You need to give some more support to people in the community. At this point in time it appears like decisions can be made with no recourse for appeal action and again that makes us feel very powerless. We need to feel that we know what's going on, first of all, and that it's something that's compatible with us.

The Chair: Thank you for your presentation, folks. We appreciate your interest in our process.

CHAMBER OF COMMERCE OF KITCHENER AND WATERLOO

The Chair: Our next presenter is the Kitchener-Waterloo chamber of commerce, represented by Ed Lemont, the chair, Ron Carther, the president-elect, and Glen Mathers, the chairman of the health committee.

Mr Ron Carther: Our third person may yet join us. We will proceed. Good morning. My name is Ron Carther. I am president-elect of the Chamber of Commerce of Kitchener and Waterloo. Ed Lemont, chairman of the federal-provincial affairs committee, will assist me in making this presentation.

Firstly, thank you for the opportunity to present the position of the Chamber of Commerce of Kitchener and Waterloo to this group. This presentation will deal only with the health aspects of this bill and is based on a high-level, preliminary review of the proposed amendments contained in the bill. It is the intent of the chamber's standing committee to continue its analysis of the various proposed amendments, critically evaluate proposed regulations and encourage an ongoing dialogue with the government of Ontario, this really in conjunction with the Ontario Chamber of Commerce.

As background, the Chamber of Commerce of Kitchener and Waterloo is the product of a merger of the Kitchener chamber and the Waterloo chamber in 1992, a move which recognized the need to cost-effectively service the business community for the two cities. Our mission is to serve business in Kitchener-Waterloo and be its voice in the betterment of the community.

Today, this chamber has a membership of approximately 1,200 businesses representing all sectors of the business community. Our membership includes small, medium, to the largest employers within our market who provide thousands of jobs in one of Ontario's most progressive and economically productive regions.

The chamber supports in principle the stated purpose of Bill 26, which is to reduce government spending, to promote economic prosperity through public sector restructuring and to create a climate which will attract investment, create jobs and encourage businesses to grow.

Deficits averaging nearly \$10 billion annually over the last four years and an accumulated debt of approximately \$90 billion are just not acceptable to our members, and therefore we urge the government to get its financial house in order.

In our opinion, the general initiatives proposed in Bill 26 are strategically correct. However, I would like to make several general observations before dealing with the specifics of the bill.

Tough economic decisions must pass the test of time, and from our perspective, there are two: democratic scrutiny, which you heard about, and debate, and in the government's own words, common sense.

Orders in council and centralization of regulatory powers must not become indiscriminate tools used to exploit special interests and to deny society at large the creativity inherent in public disclosure and the democratic process.

We strongly wish to reiterate that we do not feel we have a revenue problem in this province; ladies and gentlemen, we believe we have a spending problem. Spending must be limited at all levels of government.

Ontario businesses clearly require a health care system that meets the health care needs of our employees. Business also requires an effective and efficient health care system that will make Ontario an attractive place to invest and expand business activity. That creates jobs. Business is pleased that the Ontario and federal governments are both determined to effect major changes in the delivery and funding of health care, and the business community, as one of the many interested stakeholders, has much to contribute to this discussion.

Increasing demand for services and a limited supply of resources is a problem that is best addressed by cooperative, problem-solving initiatives by governments, health care providers themselves, businesses and the public. This must involve the critical evaluation of the type of public services that can be delivered and how best to reform and restructure the existing health care system to achieve effective and efficient health care delivery.

Public policymakers have a number of options, we think, any combination of which can help to achieve our stated goals. They are: increasing taxes, cutting back services, extending user fees or copayments, expanding the private sector in financing and delivery of health care, eliminating waste and duplication and introducing changes to current health provider reimbursement systems. To this point in time, Ontario governments have focused on the first two items; that is, increasing taxes and cutting services.

1110

The total cost for health care in Ontario is enormous, by anyone's calculation, representing about one third of the provincial budget. Since 1982, federal government changes to established programs financing have resulted in an anticipated revenue shortfall of \$18 billion for Ontario.

It is the opinion of business that fraud exists in the system and we urge the government to take firm action to eliminate it. However, and this is something that's very important to us, the confidential relationship between a doctor and a patient is a trust which the courts recognize, and initiatives to detect fraudulent use of health care must not, in our opinion, violate that sacred trust.

The concept of user fees or copayments should be implemented judicially. A recent COMPAS survey of the public indicates that Canadians prefer some form of copayment/user fee over an increase in taxes or service cuts as a means to control or reduce utilization of services. However, the income thresholds that trigger copayments or user fees are, we think, too low and should be moved higher. From our perspective, \$16,000 should perhaps be moved as high as \$18,000 for a single person and from \$24,000 to \$26,000 for a family. While user fees do not exist for core health services in Canada they do exist for non-core services such as ambulance services, chronic care accommodations, assistive devices programs etc.

We would also recommend that the Ontario drug benefit program adopt a sample drug plan which is currently operating, and we understand operating satisfactorily, in the province of Quebec. The objective of this plan is to reduce waste. When an individual receives a new prescription, they receive only a few days' supply and the balance of the prescription is only supplied and paid for when the patient finds that the drug has no side-effects. This eliminates the buildup of unused prescription drugs in medicine cabinets.

Surveys continue to show that many users do not appreciate the cost of services provided to them. Therefore, we urge the government to implement a system whereby an annual service confirmation would be sent back to users, for their acknowledgement, as a means of informing them of the real cost of services consumed. Feedback will assist the public to make informed choices and provide user scrutiny of bills to OHIP.

I'd like to now turn the presentation over to Ed Lemont, who will carry on from here.

Mr Ed Lemont: Schedule F of Bill 26 deals with health services restructuring. The business community is in favour of these actions which permit market forces to operate and policies which encourage institutions to capture operating efficiencies.

Part I of schedule F is amendments to the Ministry of Health Act. To the extent that the proposed Health Services Restructuring Commission applies prudent economic principles in carrying out its mandate, we support these amendments.

Part II of schedule F is amendments to the Public Hospitals Act. Ontario hospitals have demonstrated a willingness to work with community agencies to consolidate and rationalize services within and among hospitals without government intervention. The benefits are reported to far outweigh any negative outcomes. For example, in this community we have the combination of the Kitchener-Waterloo Hospital and the Freeport Hospital into the Grand River Hospital Corporation.

I would just read some of the advantages from a document that was published by that organization, some

of the benefits that they expect from the combination of the two facilities: 90% outpatient care delivery; more beds for acutely ill inpatients; more efficient in- and outpatient surgery; a more accessible emergency area; the delivery of more healthy babies; an adolescent outpatient unit; reducing operating costs; enhanced health promotion and disease prevention; and new standards in health care delivery.

Amendments which encourage this process to continue are supported by the chamber. However, due consideration must be given for community participation by taxpayers as partners. Decisions of the minister must be defensible on economic grounds and not based on political motivations.

Part III of schedule F, amendments to the Private Hospitals Act: The chamber of commerce agrees with these amendments, provided that the concept "in the public interest" has a strong economic connotation and that decisions are open to court review.

Part IV is amendments to the Independent Health Facilities Act. The chamber of commerce favours these amendments, with the exception of—and I emphasize with the exception of—those regarding the collection and disclosure of personal information. We are opposed to powers which break the confidential trust in the patient-doctor relationship. Also, we are not sure what extending immunity to the crown and the minister is intended to accomplish. It should not be intended to reduce or eliminate public accountability.

Schedule G, amendments to the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act, 1991: The chamber of commerce is in general agreement with the strategic intent of these amendments. In our general comments, we made several references to our support of the concept of copayments or user fees.

In conclusion, we support the broad strategic initiatives of Bill 26. However, we urge the government to continue to enhance the quality of democratic debate in the pursuit of achieving economic savings, improving operating efficiencies and restructuring of government.

Our members desire a health care system which meets the needs of our employees and through its effectiveness and efficiency attracts investments and business expansion in Ontario as well as improves the quality of life of residents of the province.

Governments, health care providers, business and the public are partners in our health care system and all must play a role in restructuring and reforming our system.

We previously identified six tools which can be used to achieve our health care goals, namely: increasing taxes, cutting back services, extending user fees or copayments, expanding the private sector in financing and delivery of health care, eliminating waste and duplication and, finally, introducing changes to current health provider reimbursement systems. The government should concentrate on all six of these tools, rather than the first two.

We urge the government to pursue policies to reduce fraudulent use of the health care system without destroying the confidential trust relationship between patients and doctors. Confidentiality of patient information must be protected at all costs. We support the concept of

copayments and user fees. We recommend the adoption of a sample drug plan along the lines currently operating in the province of Quebec. We encourage the implementation of policies which encourage consolidation and rationalization of services outlined in schedule F.

The Ontario Chamber of Commerce, of which we are an active member, has developed a complete discussion paper on the subject of health care reform, and a copy will be forwarded for your reference. That's this study here.

We appreciate the opportunity for input regarding health care legislative amendments, and we look forward to the continuing participation of the chamber of commerce in the process of restructuring and reform.

Mr Carther: Glen Mathers has joined us. Glen is a member of our federal and provincial affairs committee and has also been our liaison person with the Ontario chamber's working committee on health issues.

1120

Ms Lankin: I truly appreciate your presentation and your suggestions of certain areas where we should be cautious. I want to make a comment, and I hope you will accept this in the spirit in which it's intended. You say, "public policymakers have a number of options, any combination of which can...achieve our stated goals" and you list the six areas. You say government has only concentrated on taxes and cutting services, those two, with respect to health care. I take exception to that and point out to you—you say we haven't done anything in introducing changes to current health care provider reimbursement system. I have to talk about billing thresholds and caps on overall OHIP fees for doctors, alternative payment plans we've negotiated with Queen's and the whole academic staff in teaching hospitals. Those areas are being pursued, and I think it's worthwhile to mention that they should continue to be pursued.

Eliminating waste and duplication: I would think that in the health care sector, many hospitals would be duly insulted by your comments. We have been working a lot over the last number of years to rationalize services. You've pointed out in your own area some of what's gone on to eliminate waste and duplication, and government has been part of working with and facilitating that. There's much more to be done, and I acknowledge that, but I think you should acknowledge that that has been identified and is being worked on.

Expanding the private sector in financing and delivery of health care: This one is interesting. Certainly I would say not in the delivery of health care and I would have some questions about that, but in terms of involvement in financing and the private business of health care products and applications, tremendous work has been done with a health economic development unit that's been established. I look at projects like LARG*net in London where many private sector companies are being brought together with hospitals to develop ATM technology for digital compression of imaging, for long-distance consulting. That's going to improve delivery of health care services and it's going to produce a product which is eminently marketable around the world and consortia of the private and public sectors working together, which will bring revenue

back into the public sector as well as they use their consulting expertise on these projects.

I point that out to you, and I think it's important that those things be acknowledged by the chambers as well.

I would like to ask a question about user fees in the drug section. You have said that you think there should be some limits, the \$16,000 or the \$18,000, and that perhaps we shouldn't have the \$2 user fee below that. I'm inferring that and I'd like a comment on that. You also say it could help to control or reduce utilization. All the studies have suggested that with respect to seniors and drugs, the user fee doesn't do that. Do you just see it as a useful means for revenue, or if it doesn't control utilization, should we not pursue that and look at other measures?

Mr Glen Mathers: First, I think one thing was overlooked. To go back to your first comments, we acknowledge all those things; we're just trying to stress in this paper that there needs to be more looking at all the areas where there are duplications of services. Strides have been made, but a lot more needs to be done.

Ms Lankin: I tried not to be too personally defensive on it.

Mr Mathers: We mentioned the issue in Quebec, for example, where they have the sample drug program. Put that in perspective. I'm sure everyone of us in this room at some time has got a prescription, you take it home and it doesn't work for you, or it disagrees with you. You have 100 tablets in the bottle and you've taken four. What they've done in Quebec is that you get a sample, you get 10 tablets. The pharmacist charges his fee, does all the work he should do for that fee in talking to the patient to make sure the drug is being used properly. And then, only if it is good for the patient, do they go back and pay for the balance—but not a second dispensing fee, just for the balance of the medication. There is a tremendous cost saving in that.

Did the pharmacists talk to you about this? I know they've been working on this issue for a while.

Ms Lankin: Yes, trial—

The Chair: Thank you, Ms Lankin.

Mr Wettlaufer: Thank you very much for your presentation, and for coming and spending your time with us today. I especially appreciate that you made some recommendations rather than just complaining about the bill, because it's the recommendations which are so very important to us.

Interjection.

Mr Wettlaufer: You've had your time already.

In terms of the drugs themselves, do you believe that someone who is paying a portion of the prescription cost would be more willing to go out and shop around from pharmacy to pharmacy, given what we've already heard this morning, that the cost of a prescription can vary anywhere from \$1.99 to \$12.50, depending on which store they get their prescription at? Would you support the view that the patient might be willing to shop around more?

Mr Mathers: I think the patient may be willing to shop around a little more, and sometimes when it comes to getting a prescription they're maybe not completely out

of yet, because a lot of people stock up before they go away on a holiday.

Mr Carther: I think we've all seen examples of that.

Mr Wettlaufer: So you agree with the view that the limitation should be three months as opposed to six months.

Mr Mathers: Yes.

Mr Gerry Martiniuk (Cambridge): You started off your presentation by saying that we have a spending problem, not a revenue problem, yet one of the six tools you've enumerated is higher taxes. I don't understand that consistency.

Mr Carther: What we've tried to focus on is that the first two items are typically, from our perspective, those that governments have spent the majority of their time on, and again we acknowledge the comment that perhaps efforts are starting to be made in the other four. But clearly, past governments have focused the majority of their time and energy on either increasing taxes—the flip side is to cut services. That's merely to reinforce that.

Mr Monte Kwinter (Wilson Heights): Thank you very much for your presentation. In your third item you talked about the principles of the bill, which is to reduce government spending, to promote economic prosperity through public sector restructuring, and to create a climate which will attract investment, create jobs and encourage businesses to grow. I don't think you'll find a single person in Ontario who would object to that. I think the problem we have is that the principles outlined in what the bill is supposed to do and what the bill does are two different things. That is the problem.

I'd also like to ask a rhetorical question you can answer later. Do you consider yourself a vested interest? There seems to be a mood by the government to put out publications talking about vested interests, but only selective ones, ones it feels have a bone to pick with the government. They say, "Ten great things about Bill 26 that you won't hear from the vested interests." I would be curious to know whether you consider yourself a vested interest.

Mr Carther: Let me say that I think every citizen in this province has a vested interest in the health care system.

Mr Kwinter: You say, "Deficits averaging nearly \$10 billion annually over the last four years and an accumulated debt of more than \$90 billion are not acceptable to our members." I'm sure you understand that if you take a look at the government's own projections—not opponents', not critics', but its own projections—when it finishes its mandate it will have taken the debt of the province to about \$120 billion and it will not have balanced the budget.

Through this whole exercise, they will not have left the province in any greater shape fiscally but will have imposed a draconian rule on the quality of life. You are businessmen, and I'm a businessman as well. That quality of life has been the most attractive environmental—I'm talking about the broad environmental—climate that attracts business, attracts activity to Ontario. When we go out and compete for Ford, which looks at putting it either in St Louis, Missouri, or in Oakville, they take a look at that broad quality of life to get their executives to come up here and to get their investment here.

There has to be that balance. To pick up on my colleague's comment that we don't have a revenue problem but a spending problem, you can't divorce them; you can't have one in isolation from the other. You've got to work on both of them. You've got to increase your revenues because your revenues will allow you to provide the kind of infrastructure and services that make us attractive as a place to live and as a place to invest. If all you're working on is the spending, as I think we're doing now—we've gotten rid of the fat, and that's been done by successive governments. We're now cutting into the muscle. When you start doing that, you provide an environment that does not make us competitive, does not do the kind of things you want to do. Do you have any comments on that?

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Mr Lemont: I would suggest that when you reach a level of taxation that makes you uncompetitive—and if we're not at that level now, we're very, very close to it—that's not an alternative, to increase taxes. You have to look at your expenditures. And to go back to your comment, if the current government finishes its term increasing the debt up to \$120 billion and not getting the annual deficit any closer to being balanced—

Mr Kwinter: They're going to get closer, but they're not going to—

The Chair: Thank you, gentlemen. We appreciate your presentation with us this morning.

NORFOLK GENERAL HOSPITAL

The Chair: The next presenter is Ruth Pennington, the chair of the board of the Norfolk General Hospital. She's joined by Harold Shantz, the executive director. Good morning and welcome to our committee.

Mrs Ruth Pennington: Thank you for the opportunity to speak to this committee today. We too appreciate the actions taken by all parties which have resulted in these hearings where the public and stakeholders may be heard. I realize there have been announcements made this morning about which we knew nothing, so of course there may be parts of this presentation that are redundant. However, I think it is important that you do realize that there are many of us who do not live in urban areas or even in the north, where they have special problems, and that we do have concerns of our own.

My name is Ruth Pennington and I'm the chair of the board of directors of Norfolk General Hospital. As has been mentioned, I have my executive director here, Mr Harold Shantz. We are here as representatives of a rural community hospital located in the town of Simcoe to comment on some of the issues that will affect the operation of hospitals such as ours if Bill 26 is implemented in its present form. I should add at this point that our hospital is a member of region 4 and we fully endorse the comprehensive presentation made by Mr Collins this morning.

Bill 26 sets up the Health Services Restructuring Commission to deal with restructuring of all hospitals across the province as a direct result of decreased funding to these institutions. While we agree that the provincial financial situation dictates a change in the manner in

which hospitals operate, we feel that reference to the way in which these cuts are made is essential. Situations vary across the province, and we do not believe across-the-board cuts are the answer. We would also emphasize that the government's commitment to reinvest savings taken from hospital budgets into the larger health care sector is an important part of this discussion.

We are a rural community hospital serving a population of 50,000 drawn from a large geographical area in the western portion of Haldimand-Norfolk on the north shore of Lake Erie.

Rural hospitals are no different from their urban counterparts in that we have been making the necessary changes to operate more efficiently during the past several years. In our own case, we have lowered hospital patient days by 30% and reduced our number of acute care beds from 136 to 94. We presently operate below 600 hospital days per 1,000 population and do not feel that hospital services can adequately be provided to the residents of Haldimand-Norfolk at much less than this. Like most others, we have eliminated 4% from our hospital budget due to the social contract and at the same time have faced increased costs for government-mandated programs such as pay equity and employee benefits.

Rural hospitals do not usually have another hospital in close proximity, making shared services more difficult than in urban areas. In our own area, we share laboratory and speech pathology services with others. Norfolk General also provides detoxification and rehabilitation and placement coordination services to the entire region of Haldimand-Norfolk. The 80-bed Norfolk Hospital Nursing Home is also administered by our hospital.

In moving to other methods of funding, governments must take into account the utilization patterns of hospitals to ensure that adequate hospital services are provided in rural areas served by single hospitals. Across-the-board reductions to our budget would be devastating and cut deeply into our services to patients.

The sheer magnitude of the announced reductions will result in some rural hospital closings. There is a need to restructure the hospital system even in rural Ontario, and Norfolk General Hospital does support restructuring and has so indicated to the Haldimand-Norfolk District Health Council. What we do feel very strongly about is that hospitals and their communities have a right to be heard in the process. We also believe that any dollars saved in rural areas should be reinvested in health services in those areas. Rural areas tend to be underserved to begin with, so we do not want all resources to be transferred to urban areas. In fact, we believe each community's restructuring exercise should fund itself.

For our presentation, we have chosen to comment from the perspective of a rural hospital. However, we are a member of the Ontario Hospital Association. As such, we had the opportunity to provide input into the presentation they made to this committee. We agree with their recommendations and support their proposed amendments, particularly that the powers in section 6 of the Public Hospitals Act be time-limited to four years in order to preserve the voluntary governance of our hospitals.

We also have a brief comment on the government's proposed amendment to the Hospital Labour Disputes

Arbitration Act. We wonder whether the ability-to-pay criteria will be effective. Common sense would dictate that allowing arbitrators to award increases while we are downsizing and reducing our staff is not appropriate. We support the Ontario Hospital Association's proposed amendments to the Hospital Labour Disputes Arbitration Act.

In conclusion, we support the restructuring of our hospitals, provided that the communities and hospitals involved have input into decisions, whether to our district health council or other planning body. We support the establishment of a Health Services Restructuring Commission, subject to recommendations 7 and 8. We are against across-the-board cuts to each hospital's budget and we feel very strongly that money taken from hospital budgets should be reinvested in health services in their communities.

We take our responsibility to oversee the provision of health service through the governance of Norfolk General Hospital very seriously. Our concerns are real, and we appreciate your consideration of the matters presented in our brief. We did include sections of the Ontario Hospital Association's brief just for reference, and we have added our three main recommendations at the end of theirs.

This concludes my presentation.

Mrs Ecker: Thank you very much for coming to share and bring forward some concerns and comments and amendments to Bill 26. I think the hospital community has been very well represented through these hearings, and what we're starting to see in many different kinds of groups are very common themes, common concerns, and in some cases even common suggestions, which I think, as indicated by the amendments today and the further amendments, have been very, very helpful.

I have some resonance, if you will, since I was born in Simcoe, but I quite appreciate your comment about across-the-board cuts to hospitals and the impact that has. I know that the ministry and the Ontario Hospital Association, under the joint policy and planning committee, are working very hard to develop and finish the funding formula which will hopefully be able to provide appropriate guidance for allocating the moneys according to appropriate needs.

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I come from a growth region. We've heard at the hearings that every area has unique needs, and in our area they make the argument about needing more money and reinvesting because of the growth needs.

I guess the question I have is that in order to restructure within the health care envelope, which is what we've talked about doing, this means that somehow some areas are going to have to give up, while other areas are going to get more. That may come in funding of hospitals; that may come in funding to specific programs in different regions and areas.

One of the concerns the minister has had is that while we've had the local restructuring plans under way that the previous government got under way, and they've been working very well in some areas and had problems in other areas, in order to have a provincial picture we somehow need to try and stitch together all those local plans, and we have to somehow have a mechanism to

take the local input, but at the same time somebody has to make a decision about how the allocations are going to be made. Because you're right: We can't do it across the board. So some are going to have give and some are going to get.

Is it possible to do that kind of restructuring, that kind of allocation process, without some kind of body or commission? That was the intent of having the restructuring commission. With the appropriate amendments and suggestions that have been put forward, any comments on how it is possible to do that stitching together, if you will, to put together the quilt in Ontario for health care?

Mrs Pennington: I'm not really sure how the commission is intended to work, but I think the point we're really trying to make is that before anyone comes in to make changes in an area, the community, the hospital boards, have a chance to provide input through a local planning body. I presume that what the local planning body comes up with would be looked at by the commission—I don't know this—and that perhaps they would have a larger view of the province and would see how this fits in. If it doesn't meet with what they feel it should be, then we would hope they would come back and say, "This is how it doesn't fit in," and maybe we would still have input into how it would be done.

Mrs Ecker: One of the things that I think is important to keep clear is that the district health councils, as we've stated before, which I think are very much part of the process, remain very much a part of the process. In the dealings and what has happened here with your district health council, have you been comfortable with the way the DHC here has been proceeding with the work they're doing?

Mrs Pennington: I believe we're changing; tactics are being changed. There was a restructuring committee, which did not do a lot as far as the hospitals. The hospitals themselves were doing their own restructuring, but things have changed. They have assured us that they're very interested in taking a lead role. We've indicated that we're very interested in being a big part of it, and there is a meeting called already. So hopefully at least that part of it will be working.

Mrs Ecker: Yes, because I know in some areas that's been a bit of a tension between hospitals and district health councils in terms of who should lead the reform. So you think that's been resolved.

Mrs Pennington: We're hoping that they would make a good planning body for us.

Mrs Ecker: One of the suggestions that's been made is that we take the restructuring commission's terms of reference and broaden it from just hospital restructuring to very clearly articulate that there is a community side to this process as well. We've certainly heard from many community groups about the need to continue to try and shift money from the hospital sector into the community care sector. Any comments on that?

Mrs Pennington: Yes, I think that would be really important, because I think one of the points we tried to make is that we realize that savings have to be made, but we are also underfunded in some areas of the health sector; in our own area, for example, mental health and probably home care.

We feel that the purpose of removing the money from hospitals is to go into the broader sector, but we don't really want to be losing all that money because we have needs ourselves in our own community. If the commission was able to look at a larger picture, I don't see why that wouldn't work.

Mrs Caplan: Thank you very much for an excellent presentation. I want to point out to you that of your 13 recommendations, three have been addressed in the amendments that were tabled today, and I want to go over some of the ones that have not been addressed. You made some excellent and very thoughtful recommendations, and I hope the government will listen to what you've made.

Even though the Ontario Hospital Association and many hospitals that have presented before the committee have recommended that the minister not be able to delegate his powers, those provisions remain. I think there's a general consensus, and I agree, that if you're going to have a hospital restructuring commission, it has to have the ability to implement plans. But what this bill does is give them the power to make the decisions, and I think—would you agree?—that's what people fear. Also, the view is that given the accountability, the minister should be accountable for making those decisions.

Mrs Pennington: Absolutely. We feel that he should not delegate his powers.

Mrs Caplan: I want to go on record as saying I will not support a commission if it has those kinds of powers. I would support it if it was advisory to the minister and given the authority to implement plans that the minister had approved. I will go on record today and say that, because I was disturbed that it was not included in the package of amendments tabled this morning.

Secondly, they have addressed the suggestion of notice of 14 days and one month. You can tell us if you think that is reasonable or not, but they have addressed it today. You have time to think about that.

The question I have is your concern about the process. This bill does not guarantee any process. There's no role identified for the district health council, and while we've had some assurance from the government that the DHC's role will not change—because it's in other pieces of legislation—as an advisory planning body to the minister, I have heard Jim Wilson say they intend to change the DHC's role back to what it was originally intended 20 years ago when a Conservative government brought it in.

Would you feel more comfortable if there was a section in this legislation that guaranteed a role—I'm not talking about power, I'm talking about a role—for the district health councils and a requirement that, before a minister can approve any restructuring plan, there had to have been a community process and public hearings and so forth?

Mrs Pennington: I don't think we'd have any problem with that. As we have stated, we're very concerned that we do have a local planning body that has input, and the district health council should be able to perform that role. We certainly wish them to have a role.

Mrs Caplan: You recommended that the power to appoint hospital supervisors be time-limited, and that was not included in the amendments. Again, I think that while

there is general agreement that if a hospital board should resign en masse, the minister must have the authority to appoint a supervisor, that's a very exceptional circumstance.

Can you think of any other circumstance where a minister would want to wipe out a voluntary board of governance by appointing a supervisor, given the fact that he already has the power if he's concerned about the fiscal behaviour of that board or jeopardizing patient care because of the decisions of that board? I'd ask you to comment on the effect on voluntary governance of that provision if it remains as it is.

Mrs Pennington: I think it could have an effect. There could be people who would feel that perhaps their contribution would be of no use in that case. I don't know enough about the supervisor's position to know exactly how that would fall out but, to me, that would be a very unusual circumstance.

Mrs Caplan: There are a couple of recommendations that you have here about issues that are not actually included in the bill. There are no guarantees or commitments from the government that they will not reduce space budgets arbitrarily or across the board, and I understand your concern.

This is not a partisan comment, but I was very disappointed that the previous government did not proceed with the reallocation funding formula. I think it is the way to go. That was worked out with the Ontario Hospital Association joint committee, and I think it will make it more difficult now to implement that kind of formula without having had the opportunity to have had it done last year as well.

I understand your concern and I have always supported reallocation funding formulas. As you know, the equity funding formula was the first step in that direction, but that's not included in this bill and there's no guarantee that that will be done. Neither is there a guarantee, and in fact they've done the contrary—dollars that are saved will not in total, or in any specific portion, be guaranteed to be invested in a local community. Jim Wilson has made that absolutely clear so I doubt that they'll accept that recommendation on reinvestment in your local community.

Thank you for an excellent presentation.

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Mrs Pennington: I might just comment that we realize several issues we addressed were not particularly in the bill, but we wanted people to know that it's the way in which this is done and that we have some concerns in that area.

Mrs Caplan: It would have helped if you had health legislation as opposed to a fiscal policy before you, I agree.

The Chair: Thank you, Mrs Caplan. Did you want any time, Ms Lankin?

Ms Lankin: Maybe just a minute or two. Actually, I don't think I will take all my time. I think Mrs Caplan covered a number of the areas that I was interested in.

I do want to explore one issue just a bit further, though, and that's about the appointment of supervisors. I recognize that you indicated that you're not too familiar with how that section of the act works or when it has

been used, and that's because it has rarely, rarely been used. The existing section gives the minister the ability to appoint a supervisor to go into a hospital—

Mrs Caplan: After inspection.

Ms Lankin: —I know that, Mrs Caplan. I'll get there—when there are concerns about primarily quality and level of patient care, something of that nature that's wrong. There's a process that's set out and there's an investigator who's appointed first.

Mrs Pennington: Yes, I understand that.

Ms Lankin: There's a report that's prepared, and the hospital gets a chance to respond to the report and then a decision is taken about appointing a supervisor. The supervisor's role is clear in terms of working with the board, and any major decisions of the board have to be checked with the supervisor. That's true—there are a lot of checks and balances, I guess is the best way to say it—but even that has only been used a couple of times in the history of the province. When I asked the Minister of Health, because he said this would be extraordinary and there was a rarely used existing section, "Why do you need more powers if you don't use the existing section often?" he didn't really answer and couldn't really answer that question.

Here's my concern about what's in the new bill, which is that the minister can appoint a supervisor any time he wants. The amendments we saw today simply say he has to give you 14 days' notice now, so at least you know it's coming. But there's no process for you to be able to respond or to get a response back from the minister. I would think the government would say that's assumed, but usually that ability to respond in writing and to get a response or a hearing with the minister, whether it would be set out, that's not set out in the amendment.

The supervisor can still take over the day-to-day operation of the hospital, and those words are right in the legislation. The hospital board has no ability to make independent decisions at all. It used to be they could make decisions they'd have to check with. Now that's stripped, so the voluntary board is stripped. The reasons that you can send someone in are expanded to include the fiscal situation and resources available. I'm assuming that the time the government thinks they might need this is if they're trying to close a hospital and for some reason the board is just absolutely digging in and refusing to cooperate and be closed. It's the only thing I can come up with in my mind.

It seems to me if that's the reason, it would be useful to set out the criteria in the legislation of when the minister is able to use this extraordinary power and that for any other reason you have to go through the normal process where there is an investigator's report and an opportunity for the hospital to respond. It's a quality issue. There's a process that's served as well in this province. That's one suggestion I would make, and I'm interested if you would agree with that.

Secondly, I really believe that if they are taking this extraordinary power with respect to supervisors and taking away the voluntary governance of a hospital in extraordinary circumstances related to closures, that also should be time-limited to the four years, the same as other aspects of the bill which they've agreed to with

respect to closures and mergers. Could you comment on those two recommendations for amendments?

Mr Harold Shantz: I believe that the necessary power is there already in the act and what has been added is just to extend that power. I would agree that the only time you'd use that is in a closure situation by the way it's set up, because the additional items that have been added there have to do with the proper management of the system and financial resources.

Ms Lankin: So would you be supportive of those kinds of amendments? We didn't see that today from the government, but I will continue to push the government in that direction.

Mr Shantz: Yes.

Ms Lankin: Okay. Mr Chair, I'm going to give up the rest of my time. I appreciate the presentation, it was very thorough, and I understand the issues. The two out of the 13 that they've agreed to is great; the other 11 we'll continue to push for.

The Chair: Thank you for your presentation this morning. We appreciate it.

KITCHENER-WATERLOO ACADEMY OF MEDICINE

The Chair: We're entertaining an extra group at lunch today and it is the Kitchener-Waterloo Academy of Medicine, represented by Dr Pierre Kugler, the president. Good afternoon, doctor. Welcome to our committee.

Dr Pierre Kugler: I'd first like to thank the members of this committee, and especially Mr Carroll, for accommodating the academy of medicine today over their lunch period. I'm sure after the morning people are very hungry and the minds are very numbed, but thank you for giving me the opportunity to speak.

My name is Dr Pierre Kugler. I am the president of the Kitchener-Waterloo Academy of Medicine, representing the physicians in this community. I shall be joined in a moment by Dr John Wright, a family physician from Owen Sound, who is a member of the board of the OMA.

The Chair: Just for your information, doctor, to give credit to all the parties, they all agreed to your presence here at lunchtime, so I can't take credit for it.

Dr Kugler: Then I'll thank all the parties present.

I could walk in and start to deal with specifics on Bill 26 right off the bat; however, I thought it might be best if we could start very quickly with something of a history lesson. I'd like to go back, if I may, to the spring of 1986. The Liberals had just been elected to power in a minority government and, largely at the urging of the NDP, then-Premier David Peterson decided that the health care system was not working.

Mr Peterson told the public that the way to make the health care system work better would be to strip physicians of their professional autonomy, deny them the right enjoyed by every other profession in the province of Ontario, that is, the right to decide what the value of their services they provide are worth, and ban what they called extra billing or what the profession called balanced billing.

Again at the urging of the NDP they painted a picture for the public of a society in which only the wealthy

could afford health care and no one else could. This in fact was not the case but they did do a very good job of creating a climate of fear and mistrust among the public and Bill 94 subsequently became law.

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Five years later, in 1991, the Liberals were no longer in power. Bob Rae had been swept to a majority government in 1990. The problems facing the health care system, such as shortages of primary care in remote regions of the province, were worse than they were before. Many of our best specialists were now working for Uncle Sam instead of Big Brother Bob, and Mr Rae then told the people of Ontario that the way to solve these problems and improve the delivery of health care in the province of Ontario was to set individual caps on what any physician in any given year could earn. The public, still dealing with the fear and mistrust generated in 1986, embraced this concept, as did the media, and income caps became law.

By 1993, the problems of waiting lists and physician shortages in remote areas, were worse than they were two years earlier, and the province was dealing with ballooning debt and deficit as well, for which Mr Rae again said the doctors were to blame. He told the people of Ontario that the way to improve the health care system was now to set a global cap on how many services would be paid for by the province of Ontario in any given year, with any excesses being recovered from the profession in subsequent years. The people of Ontario seemed quite willing to forgive any failings of earlier legislation and again embraced this concept wholeheartedly and the social contract became law.

Now in 1995, this region, the Kitchener-Waterloo region, for the first time in its history is dealing with a shortage of primary care physicians; that is to say, family physicians. The question is, how did this happen? There are several reasons for this.

In the past year, four family physicians have relocated to the United States. That's four more than have relocated in any given year prior to that for the past decade. There has been normal loss of physicians through attrition; that is, retirement and death.

The thing that distinguishes 1995 from previous years, ladies and gentlemen, is that young graduate physicians no longer seem to be coming to this region to establish a practice, and many other regions are having that same difficulty. The primary reason for this, it is believed, is that a graduating physician, who already has incurred from \$25,000 to 50,000 of student loan debt, does not wish to supplement that debt by another \$50,000, the approximate cost of establishing a practice in this province, only to face a very uncertain future, which is what physicians have faced since 1993 under the social contract. So we continue to deal with a primary care shortage.

Now, in 1996, we have before us Bill 26. I am forced to ask the Conservative members of this committee and of caucus, members who campaigned on the platform of less government and less regulation, if they have learned much of anything from the failings of their predecessors.

The problems, if there are problems facing the health care system, of shortages of service, waiting lists, short-

ages in underserved areas, have failed to be legislated out of existence by previous governments. I wonder about the rationale the government has in thinking that this legislation can succeed where others have failed. I feel the solution to the problem, again as was stated during the campaign by the Conservatives, is not more regulation but less intrusion.

Dr Walter Rosser is the chair of the Department of Family Practice at the University of Toronto. His polls of family medicine residents show that up to 80% of the graduating class is seriously contemplating relocation to the United States, again because of the uncertainty we as physicians face in this region. I am uncertain how this legislation will be able to reverse that trend.

Surveys by the Canadian Medical Association show that Canadian doctors practising in both Canada and the United States have left largely because of the uncertainty they face in this country and this province at this time. Between 1988 and 1993, the number of physicians leaving for the United States increased by a total of 245 per cent, roughly 30% per year. Health Canada data for 1994 indicate that the number of Ontario physicians leaving the country compared to those returning from abroad is a ratio of about 4 to 1. In the high malpractice premium specialties such as obstetrics, orthopaedics and anaesthesia, this ratio could be as high as 8 to 1. This could be exacerbated by the recent decision to discontinue CMPA rebates to some of these professions.

Basically, we have a climate now in Ontario that is not attracting physicians to regions like Kitchener but is in fact driving them away. The costs of establishing practices are prohibitive, the assurances of reasonable income that would allow an individual to meet the expenses of day-to-day practice are not there and physicians increasingly feel that they are being told they're a part of the problem instead of being treated as part of the solution.

The ministers of Health in both this administration and previous administrations have stated that doctors are part of the reason why the province is facing a financial crisis. I am forced to ask, is this true? Many facts are in dispute. According to our statistics, since 1990-91, utilization of the health care system per capita has risen at an annual rate of 1.1%. This is not the uncontrolled growth that the ministers have referred to.

We also know that we have an aging population. Those residents of Ontario over the age of 65 have increased by upwards to 60% between 1981 and 1996. The cost of providing medical services to a senior are significantly higher than for younger patients. In 1993-94, the number of medical services provided per patient to individuals in the 70-79 age group was 31.1, while it was only 17 services per patient in the 30-39 age group. The cost per patient in the 70-79 age group was close to \$762; the cost per patient of the 30-39 age group is about \$390. Yet the prevailing sentiment we get from all three parties, from the media and from the public is that we are the ones responsible for this increase in cost.

The 160 million services provided by all physicians translate to less than 15 services per Ontario resident per year, or approximately 1.25 services per person per month. The Ministry of Health has talked about a 10% rise in services per patient since 1987. This translates to

approximately a 1.4% increase per year. This does not seem to me to be putting the financial strain on the province of Ontario that we are told.

In summary, I just think that there are very few in this province who would say that the delivery of health care in Ontario is better now than it was in 1986 when this story began. What we have seen in the last decade are exercises in trying to improve the government's bottom line, but I am not sure if they have been able to translate into improved delivery of care.

Bill 26 is a truly remarkable piece of legislation, amending 44 acts, creating three new ones and repealing two others, and allowing for sweeping and unprecedented powers to a handful of cabinet ministers. We can debate, and have debated over the last few weeks, the merits and the pros and cons of this legislation ad nauseam. As a physician, however, and as a representative of the physicians in this community, I can only address those issues relevant to health care and specifically to physicians. I fear that the powers being given under this bill to the ministers to, in theory anyway, tell physicians where and how to practise medicine, regulate how they would work up, investigate and treat patients, and review confidential records will do more damage to the system than good. I fear that this, like every other piece of legislation we've seen since 1986, will only exacerbate the problems that we're trying to correct.

1210

Mr Wilson, when campaigning prior to the election, said that to make the system work we need to first re-establish the trust and the cooperation of the physicians of Ontario and undo the damage that had been done in relations between government and the OMA in the past decade. I don't think Bill 26 will do that.

In conclusion, I'd like to leave you with one more thought. Groucho Marx once said that politics is the art of looking for trouble, finding it everywhere, diagnosing it incorrectly and applying the wrong remedies. The exercises we have seen in the past decade would tell me that the spirit of Groucho is probably alive and well in Ontario. I would ask the Conservative members of caucus, again who campaigned on less regulation and less government intrusion, to reconsider some of their positions on the issues of health care as it applies to the delivery of health care directly by physicians in the province of Ontario before January 29. We're open to questions.

Mrs Caplan: I would like to explore the issues of manpower planning and distribution. They have been a problem in the province for a long time. I thought I'd start out by telling you that I do not support billing numbers and never have. I think they're the wrong solution and that there are other solutions. I would like to ask if you support the recommendations of the College of Family Physicians of Canada. I understand the OMA also supports the notion of patient selection and rostering.

Dr Kugler: From my perspective, again, I am not well-read in that particular issue. Perhaps Dr Wright would like to address that.

Dr John Wright: If I might, the work on primary care reform within the OMA is an ongoing project under the care of Dr Wendy Graham. We are indeed looking at

what the benefits of rostering would be in order to try to eliminate waste and so on. We are quite willing to explore those concepts and have shared some of those ideas in their preliminary state with the minister. We are willing to continue to explore those, in addition to a number of methods of alternative remuneration.

So far, as we have gone to some of the alternative plans, problems have occurred in the interface between the fee-for-service system and taking money out of the globe to pay for the new system and what counts for what. We're told that services that should be paid for under some of those plans now are being cost-shifted out into the community and some of the centres that are receiving capitation or salaries are no longer doing the work that they were doing before. So it's a complex problem.

We have proposed an economic incentive program for northern and rural underserved areas. It needs some time to work. Okay? You cannot try it out for two or three months and say, "Well, it didn't work, and therefore we're going to impose some other drastic system." I can say that when, under the former administration, there was a suggestion that young physicians would not be allowed to work anywhere they chose and that they might have to go to underserved areas, and there was a lot of publicity then, that was when the Lake of the Woods district and Red Lake and Hanover and all of those areas began having the problems for the first time that we couldn't get locums to come to rural areas.

I was seriously ill about a year and a half ago and needed a locum and could not get one under any circumstances because our young people are so frightened of the prospect of being locked into an area when they haven't decided that's where they want to stay. So we have to be very careful how we apply some of those.

Ms Lankin: There are two issues I want to touch on. First of all, in the amendments that were tabled this morning to the Public Hospitals Act, there are some changes with respect to the issue that we have been discussing with doctors about revocation of hospital privileges. Under Bill 26, in the situation where a hospital closed, privileges could be revoked and there was no appeal. There were other sections in Bill 26 that said that if under any other circumstance the minister deemed, that could also happen, essentially.

The amendment we saw today actually clarifies what the intent of that was and takes the broader nature of the power away, but adds to hospital closures the circumstance where a hospital ceases to provide a service. So in hospital rationalization of services, where services perhaps are amalgamated and moved to another site, the question will remain whether doctors have any ability to follow their patients and their work there. I'd like you just to comment on that and whether that's a satisfactory amendment or whether there are still problems or there's more that needs to be done.

You referred to a few of the specialties and the problems around the CMPA rebate. The minister has indicated that he understands the issue with respect to obstetrics. We don't know what he's going to do about it—we haven't seen any amendment on that—but there are other specialties you mention. Could you tell us, if he

fixes obstetrics, is that good enough, or are there other areas where we're going to be short on specialists?

Dr Wright: Who would you like to hear from first, and on what?

Ms Lankin: Perhaps on the privileges first.

Dr Wright: On the first one, we have not had a chance to study or see those amendments in detail. We'll be looking at them.

I think the overriding thing throughout all of the medical parts of the act is the fact that due process is abrogated, the right of appeal is abrogated; the right to have an understanding that things are not going to happen in a totally arbitrary fashion is really the crucial fear that is gripping the public and gripping the medical profession and gripping the entire health community. That absolutely must be addressed in all parts of the act.

I'd like to make one quick point about confidentiality. That is, I have had patients in the last few weeks starting to ask for the first time in numbers that I not record what they're telling me in the record. That puts me in a really difficult position, because the College of Physicians and Surgeons says I have to, the medical review committee says I have to, but the patients do not want it recorded that I've ordered an AIDS test or that they've discussed something and is this a risk factor, or the family problems they're having. There are real problems with this legislation.

Ms Lankin: And CMPA, a quick comment on that?

Dr Kugler: I think it is a good thing that the minister has recognized the issue of the high premiums faced by obstetricians and gynaecologists in this province. There are, however, other specialties such as orthopaedics and anaesthesia that have exceptionally high premiums as well, again, orthopaedics being an area where we have a shortage in this region as well, with no evidence or no signs that any young graduates from orthopaedic residency are planning to relocate to this area.

I don't see the present legislation and the withdrawal of CMPA rebates helping that situation at all. So we have something of a shortage of orthopods right now, but that will be exacerbated in the next few years as older orthopods retire, and if younger ones are driven out of the country it will only be worse.

1220

Mr Clement: I wish to defer to Mr Wettlaufer after asking a question. I'm glad we were discussing the situation respecting underserved areas, because it's been a concern of previous health ministers and governments for two decades that, because of government's fault and that's a portion of the blame, we haven't tried hard enough to solve it, I suppose is the way to put it.

My view, though, is that the situation right now—and I think this is what you're saying—creates a two-tier health care system, because in some areas you have no access to a doctor and that is a different tier from those who have access to a doctor. So we're talking about a very critical problem that we face in Ontario and we are looking for different solutions, rather than the ultimate weapon, if you will, being restricting billing numbers, and the minister has made that clear.

Some doctors have come before this committee over the past couple of weeks and said: "Look, we're keen on

differential fees. We're willing to apportion among ourselves differentially to reward those serving in the underserved areas." Do you have a reaction to that?

Dr Wright: In general, if you look at the incomes of doctors who are in the underserved areas, and if I take the extreme example of the north, they're the highest-paid doctors in all of Ontario. What they tell you is that they don't want more money; they want more time. They need relief. They need people to come to share the workload.

However, you have to have people who are appropriately trained, and we have been working on providing special training for people who wish to go to rural areas. You really have to have somebody who has the training, who has the interest and who wants to stay there.

I don't think solutions that are going to force people there when that's not where they want to go or only for economic reasons—this is a big, multidimensional problem and simplistic solutions are being suggested. That's why our program looks at leave, looks at continuing medical education, and I would suggest that the government revisit that incentive plan and look at it carefully and look at every element that's there and why it's there, because those are the things that the doctors in the underserved areas tell us they're looking for.

Mr Wettlaufer: Thank you, doctors, for your presentation. I'm somewhat sympathetic to the plight of physicians in this province. I am a little bit concerned, however—I have a background in insurance—about the size of your surplus in the CMPA. I'm not going to speculate on how big it is or how much too much it might be, but I was wondering if the OMA might consider petitioning the CMPA for independent actuarial advice to determine whether or not it is in fact too large or too small, and if it would be too large, that it could result in a lowering of insurance premiums.

Dr Wright: The size of the so-called surplus is really just the amount of money that the actuaries have told us is required to be set aside for future settlements, and unlike many government programs which are sort of a pay-as-you-go—"If there's a claim this year, we'll get it out of taxes this year"—I paid my premium for work that I did in, let's say, 1975 and moneys were set aside for any lawsuit that arises in the future from that year. That is what that surplus is. It is not money for doctors, it is not money for the CMPA; it is money to pay out claims to patients when the courts decide that there has been negligence.

There are a number of things that could affect that. You could look at tort reform. That's not always very popular with the people who would say they're being victimized and not being allowed to have the type of settlement they need so that they can go on with a decent standard of living if they happen to suffer a medical catastrophe. But I think there's a great misunderstanding about what that surplus is.

You have an unfunded liability in the Workers' Compensation Board that you are concerned about.

The Chair: Thank you, doctors. We appreciate your attendance with us this afternoon and your interest in our process. Thank you. Have a good day.

Just a couple of housekeeping notes: We have to check out by 1 o'clock. You can leave your luggage at the front

desk, those travelling on the bus, and we are recessed until 1 o'clock.

The committee recessed from 1226 to 1301.

WATERLOO PUBLIC INTEREST
RESEARCH GROUP
WATERLOO REGIONAL
COUNCIL OF RETIREES
WATERLOO REGION
DISTRICT HEALTH COUNCIL

The Chair: Good afternoon, ladies and gentlemen. It is 1 o'clock, and that's the advertised time to start. We do believe in respecting our guests' time frame, so we're going to start on time.

Our first presenter this afternoon is the Waterloo Public Interest Research Group. I don't have your names, so I'd ask you to introduce yourselves.

Mr Daryl Novak: Good afternoon. My name's Daryl Novak, and I'm a staff person with the Waterloo Public Interest Research Group, WPIRG. We have chosen to share our timeslot, so I will be making a very brief presentation in order to give time to George Goebels, representing the Waterloo Regional Council of Retirees, and Gavin Grimson, representing the Waterloo Region District Health Council.

WPIRG is an incorporated, non-profit, non-partisan, volunteer-directed organization based at the University of Waterloo, with a membership of over 13,000 students and community members. Our mandate is to research, inform and take action on issues affecting our community's wellbeing, and we support any measures taken by the current government to foster constructive social change, providing the measures respect the diversity, equality, dignity and civic participation of all members of our community.

Unfortunately, in our view Bill 26 falls far short of these criteria and appears to meet others; namely, expediency, privatization and profit.

Health is so much more than being able to see a doctor. To create conditions for good health people need access to employment at decent wages, adequate housing, education, food, a clean environment, peace, a strong social safety net, and safety in the workplace. If public policy does not enhance these conditions for everyone equally, it simply is not good public policy.

Certainly the citizens of Ontario are concerned with the provincial debt and inefficiencies in the delivery of government services. However, WPIRG fundamentally believes in the right of people who are affected by decisions to be an equal participant in the planning process. For the government to unilaterally suspend the rights of citizens and wield extensive new powers to introduce irrevocable changes is nothing short of totalitarianism.

This might seem like strong language, but let's look at the facts:

(1) We are all quite familiar with how this government attempted to put this legislation through without debate and how the current timetable does not allow for meaningful stakeholder participation. Many democratically run organizations, including our own, could not orchestrate an

adequate review of a bill of this nature in such a short time frame.

(2) This bill gives powers to the cabinet that will be beyond the reach of parliamentary debate or public discussion.

(3) This bill contains no provisions for public input or appeals.

(4) This bill excludes health care providers from the decision-making process and leaves them without a meaningful arbitration process. For example, there is no mention of district health councils, and considering other elements of Bill 26, it is apparent that decision-making on the local level has been deemed expendable.

(5) This bill will give cabinet the power to completely override local hospital decisions.

(6) This bill limits access to government documents, particularly for individuals, and increases fees to be paid under the freedom of information act.

(7) Finally, this bill protects the government-empowered decision-makers from any liability or court challenges.

It seems that everything this government is doing is a disincentive to people to be civically minded. You want the public to stand back and absorb the changes that you will tell them are in the public interest. You cannot create a culture of participation and community cooperation by proclamation while eliminating mechanisms for meaningful involvement.

We do not support the status quo. If this government would consider one recommendation from us, we would ask that it extend the period of review of Bill 26. Functional democracy demands the use of checks and balances. Democratic principles should not be sacrificed for expediency. This government should be engaging everyone in the process of reforming the health care system and building consensus and reaching compromise that the entire citizenry will stand behind, not just those who stand to profit.

Although the government might not agree with us, we would like more time to make our case for a health care system based on universal coverage, equal access, public non-profit administration, comprehensive care from large institutions to the home, affordable drugs, expanded methods of health care and fair treatment of health care providers.

I recently spoke with a senior citizen on social assistance who just won \$5,000. When I asked her what she was going to do with her money, every item she mentioned centred around her health needs that had been neglected for some time—her teeth, a new pair of glasses. I hope this doesn't become the legacy of the current government.

Mr George Goebels: George Goebels, with the Waterloo Regional Council of Retirees. For some time now the people of Ontario have been inundated with leaks of what the provincial government is proposing in the Legislature and has finally tabled. Some of these cuts have already been instituted, such as a cut of 21.6% to welfare assistance.

Kitchener MPP Wayne Wettlaufer is quoted in an article in the K-W Record as having said that the Tories picked easy targets first. These easy targets were the people on welfare, senior citizens and the disabled. They

seem to have chosen this route instead of closing tax loopholes and many and various other ways such as tax deferrals—you name it. They don't seem to want to hurt their wealthy friends. Cutting day care subsidies will hurt the lower-income people first and most.

A real radical proposal now tabled is what Premier Harris has referred to as copayments or deductibles but is nothing less than user fees. All those single individuals with an income of under \$16,000 a year and families with an income under \$24,000 will pay \$2 on every prescription. The ante goes up as your income does.

If there are seniors who will be able to afford these user fees, I haven't had the pleasure of meeting them. People on welfare, even before the 21.6% cut, were on a mere existence level, and I have no idea how these people can be expected to pay \$2 on every prescription they may need to sustain some measure of health and dignity. If there are people on welfare with an income that they should be or are paying income tax on, should they really be receiving welfare?

1310

It seems that the poorest of the poor—the disabled, the seniors and people on welfare—are being blamed for the high cost of drugs. Why, for a change, isn't the blame put where it belongs? Some years ago, the federal government passed Bill C-22, which gave international drug manufacturers a 10-year guarantee that no generic drug manufacturer could copy or produce a similar drug. Then came Bill C-91, which changed the 10 years to 20 years. If this bill were scrapped, it would likely reduce the cost of drugs, but I question whether a provincial Conservative government would try to get a former federal Conservative government's bill scrapped.

Isn't the real reason the cost of drugs is skyrocketing, as Premier Harris claims, due to the 20-year guarantee? Premier Harris, in an article in the same paper, seems to be covering his behind by insisting his government is not breaking an election promise. If drugs are not part of health care, I am sure I don't know what they are. He claims, further:

“What we've indicated so far and we're committed to is we will respect the Canada Health Act, which calls for no user fees for those services which are deemed to be medically necessary.” And he adds: “There is debate which services are necessary. We respect the Canada Health Act and we will live with that.”

“But the Premier argued that the drug plan is not, in the government's opinion, a medically necessary service. He also claims: ‘There is no obligation on the government to provide anything. The drug plan is one of them.’”

“The proposed legislation will require recipients to pay a minimum of \$2 per prescription in user fees. The annual charges a person could face might add up to thousands of dollars, he said.”

Throughout that whole article, and since the mini-budget on November 29, 1995, the Premier is really playing with words. It is also clear since then that the government is giving itself dictatorial powers never before seen in this country by any government. This could only be the start of what he probably promised his friends is to come, namely, the elimination of the Health Care Act.

The new bill the government tabled that day, called the government Savings and Restructuring Act, 1995, which was to be passed by the Legislature by December 14, 1995, gives it power to do practically anything it likes by order in council or, in some cases, by the minister involved. We thought Hitler was bad. It looks like we are in for worse than that.

Here in Ontario, because of our deficit, our new Conservative government plans to put its fiscal house in order. That's good. However, it has unjustly targeted the poorest of the poor and the marginalized people to carry this out, to give more tax breaks to their wealthy friends.

Some of the most disturbing of their recent decisions have been: the 21.6% cut in social assistance rates; the introduction of increased qualifications and requirements for the disabled; user fees for the above and seniors on drugs; the moratorium on non-profit housing; the closing of women's shelters; the reduction of day care. Why do the poorest have to pay the deficit reduction alone?

We therefore ask you to work on the real problems. We realize that the Ontario drug plan may be in trouble. To get out of this problem is not only to take from the have-nots. We must all work to eliminate Bill C-91 and force the multinational drug manufacturers to compete with the generic drug manufacturers in an open market. This, without a doubt, should reduce prices.

It seems most of this foolishness started at the federal level when that government reduced transfer payments to the provinces. Now the provincial government, just as foolishly, cuts the grants to regional and municipal governments, as well as most service agencies. These are now expected to raise more or most of their needs locally. The money will again have to come from the have-nots instead of those who control our destiny.

It is the responsibility of the provincial government to subsidize local governments and charitable organizations. Many charitable organizations save senior levels of government a lot of trouble and money by providing services the government is unable to. Charitable organizations need these subsidies if they are to continue to do the jobs they were set up to do. Raising money locally just to survive was not and is not part of that job.

On the second last page of the other section, escalating drug prices are mentioned as the cause of user fees for drugs. So what happens? Price controls on prescription drugs will be removed. This alone will guarantee that the cost of drugs will rise. Caring Ontarians and Canadians decided a long time ago what kind of health care system they want and have and do not want to see it destroyed. The public's access to information about the government's activities will be more strengthened by raising the fees charged for same. Organizations will also have a new right to completely refuse to deliver the information requested.

This bill probably covers nearly everything, over 40 different laws. Even lawyers and legislators seem to have a real problem interpreting it, partly because of its vagueness. Yes, this government is giving itself dictatorial powers. It looks to us as if fascism is just around the corner in this province. God forbid.

Mr Gavin Grimson: Good afternoon. My name is Gavin Grimson, executive director, Waterloo Region

District Health Council. To my right is Joyce Cruikshank, formerly chair, Waterloo Region District Health Council.

First of all, I would like to thank Daryl for allowing us to share his spot on this presentation to committee. Waterloo Region District Health Council is one of 33 district health councils in Ontario, covering 100% of the province's population. Over 8,000 volunteers contribute more than one million hours province-wide every year to community health planning through DHCs.

With some reservations, Waterloo district health council generally supports the government's method for implementing hospital restructuring. Waterloo district health council is willing and able to provide input and support to maximize the value of the Health Services Restructuring Commission. The critical link between local planning and implementation has to be maintained. Needless to say, the district health council believes that local planning makes a significant contribution to achieving cost savings across Ontario and local planning has an ongoing, essential role in developing integrated health service delivery systems.

Most of the comments that I will make now refer to schedule F of Bill 26. The roles and responsibilities of the commission and district health councils must be clarified to ensure that planning and implementation of integrated health service delivery systems are carried out smoothly and effectively to the benefit of patients.

Decisions of the commission should be based primarily on planning and analysis conducted by councils to ensure that community health needs are addressed through an approach to developing an integrated health service delivery system.

Implementation of hospital restructuring must ensure that community health needs are met through alternatives to hospital services which have either been downsized or eliminated. There is a close relationship between the commission and district health council and this is critical to advancing the implementation of hospital restructuring.

Implementation, wherever possible, should be done by consensus to serve the health needs of the community, and the community should, wherever possible, be included in this exercise. Only as a last resort should the commission be brought in to bring the various parties together to ensure that the needs of the community are met in the most efficient, effective and economic way possible.

1320

To some extent the commission is seen as a roadblock buster to bring to the attention of the minister changes to regulation, policy, bureaucratic red tape that are necessary to advance reform; to analyse common trends that impede implementation of restructuring activities, recognizing the need for local communities to, wherever possible, chart their own course within provincial parameters that reflect the health care needs of their community.

Schedule F, the structure and composition of the commission: The commission structure should be based on clearly defined roles, expectations and responsibilities. District health councils and providers and the community should also have clearly defined expectations and responsibilities.

Cost savings and any reinvestments achieved through hospital restructuring: It is believed that there should be

a formula for reinvestment in the community of cost savings achieved through any restructuring to ensure that resources required to provide health care are those that are required within the region.

New models for health care facilities and physicians should provide incentives to improve utilization management to encourage the development of alternatives, satisfactory levels of care and the enhancement of community resources wherever necessary. Incentives should also be provided to facilities and organizations to encourage new and innovative directions in care to the benefit of patients and public.

Benchmarks: There's a critical need for aggressive planning benchmarks for health services which are public and agreed to to ensure that the health care system is responsible to the needs of individuals.

A relationship between local planning and implementation is critical to the success of hospital restructuring implementation. Without clear directions, roles and responsibilities, confusion and public dissatisfaction will arise.

Recommendations re the Public Hospitals Act: The caution is that the appointed hospital supervisor may play a necessary role in the implementation of health service restructuring. However, voluntary governance provides a mechanism for critical community input in decisions affecting local health care and this should be respected in the decision-making process.

Again on schedule F, part III: Decisions on the operations of private hospitals should be based primarily on analysis of local health needs that are provided through district health councils currently.

Universal access to the best possible primary care, treatment and medical technology is highly valued by Ontario residents and should continue within the government's fiscal framework. This is only possible if provincial standards on the numbers and types of health services and facilities are established within the context of ensuring universal access to high-quality health care.

Schedule F, the Independent Health Facilities Act: Licensing, funding and quality assurance of non-hospital health facilities that provide selected varieties of diagnostic and treatment services should be assessed within the context for developing integrated health delivery systems based on the community's health needs.

Brokerage, wherever possible, should be completed at the local level. This may be required to ensure the forging of effective links between hospitals and community agencies by adding to the variety of services provided by independent health facilities.

Provincial standards on the numbers and types of health services and facilities should be established within the context of ensuring universal access to high-quality medical care. Health is so important that market forces should not determine the numbers and types of service available. Quality of care is too important and must be preserved above all else.

Schedule G re the Ontario Drug Benefit Act etc: The government should work with consumers, physicians and suppliers to control drug costs in ways that do not cause a deterioration in patient care and at the same time are more effective and economic.

Schedule H, the Health Care Accessibility Act and Health Insurance Act: The government may wish to ensure that in making the health system more responsive to all, equal accessibility is available to everyone in the province and that user fees do not create a two-tier system.

Schedule I, the Physicians Services Delivery Management Act: It's recommended that it is essential to ensure communities have access to primary physician care. The ministry should continue to reimburse physician insurance in underserved areas where the lower and fluctuating volume of cases makes for an extremely sensitive break-even point between payments received for practising obstetrics and the involved insurance costs and for all other medical services.

The government should work with all involved in health care to ensure that all health services are available throughout the province. Thank you.

Ms Lankin: I appreciate the presentations of the groups. I want to indicate to you I have a point of personal privilege, but I'll wait until the three parties have responded.

May I say to the seniors' organization, I'm sure you were around in the days when the universality principles of medicare were created. I share your worries about what this bill will mean for that and I wondered if from your position as an elder in our community you could give us some words of wisdom about the reasons for the drive to medicare as it has been created and the dangers if we move away from that universal system.

Mr Goebels: Yes, I was around quite a few years before there was any kind of health care and I hope I don't have to see it again. Most of us seniors have extended families of three or four generations and naturally we've got to think about their health care as well. We can't just give up once we're retired and let them look after themselves.

Mrs Helen Johns (Huron): I just wanted to ask a question of the district health council. Mr Grimson, I can see that you're basically working on your report and you're looking at the implementation of the restructuring. Do you envision problems? Is that why part of your support of schedule F is coming about? Can you tell us the problems that you think may happen within the community or how the restructuring will unfold?

Mr Grimson: There are always problems in any restructuring or in any change, and I think the province has seen so many councils throughout the province putting forward suggested reforms for health services within their area that have subsequently been blocked, for whatever reason, that this is seen to be a way of unblocking the blockages.

Mrs Caplan: You've been very diplomatic, thoughtful, and I share your concern which I think is implicit in everything that is in here about local planning. As you know, there is nothing that guarantees local planning in this document, and I see you nodding. You can comment on this if you wish, and I understand you need to be diplomatic because the minister has been so uncertainly clear. He has not been clear about his intention for the role of the district health councils. I have heard him say that he intends to see the role revert to what it was 20

years ago, which was simply as an advocacy group and not doing the kind of leadership and planning that we see today. I know that your role has been evolving. I was actually very pleased to hear from the Norfolk hospital, which was here, that its district health council is assuming a more significant role in local planning. So I'd like you to talk about local planning, if you could.

1330

The Chair: Thank you, Mrs Caplan. Time is up. Thank you very much, folks. We appreciate your being here this afternoon. Unfortunately, we're on a very tight time frame, so we have to run it this way. Thanks very much for your interest.

Ms Lankin: On a point of privilege, Mr Chair: I believe that my rights and privileges as a member of this legislative committee have been violated. You know that I have for days been bringing forward a motion asking for all amendments that the government was aware of and had approved and that were ready to be tabled. You know that I raised that in the first week of committee hearings and got an assurance from the minister. You know that I raised it again this morning, and what we saw were seven or eight amendments tabled and a statement at that time of tabling that there were not other amendments that were ready and that the government was sympathetic and would get them to us as soon as possible etc.

I have been made aware that there are other amendments which are ready and were ready and that members of the media have copies of those. I as a member of this committee do not have copies of those and I believe my rights and privileges have been violated.

Now, I understand that the government will be taking actions to correct and remedy this situation by tabling these further amendment, but I'm sorry, I'm very angry that we are in this situation when I have asked repeatedly for these amendments all to be tabled. If we're now going to have to get them in dribs and drabs, by whatever means we can when the media get them, I feel that will be an ongoing and continuing violation of my rights, Mr Chair. I would hope that you will look into that and you will rule with respect to whether or not my rights have been violated. Even in the event that the government now tables those few amendments, I think this issue may well repeat itself over the course of the next couple of days.

Mrs Caplan: Point of privilege.

The Chair: Excuse me a second. You folks don't have to sit there for the rest of this. It doesn't particularly involve you, so you can—

Ms Lankin: It sure does. They don't get a chance to see it either.

Mrs Caplan: Point of privilege, Mr Chairman: In fact I am outraged, because I did not even know that the media had been given amendments. I am very concerned as a member that my privileges have been seriously impinged upon. The fact that this government is giving amendments to the media before it is giving them to members of this committee is an outrage.

I have been asking for those amendments from the very first day that this committee began, and if they are attempting to manage the news and not give the members of this committee the right to review those amendments in a timely way, that we are not receiving those amend-

ments first is unacceptable to me and I would ask that you review the procedure, sanction the government and tell them that they must present and table those amendments here at this committee before they leak them to the media or hand them to the media or give them to the media. We, as members of this committee and as members of the Legislature, deserve that kind of consideration and appropriate treatment. It is outrageous that they would do that.

The Chair: Mr Clement.

Mr Clement: Thank you for the floor, Mr Chair. Through inadvertence, the procedure that we wished to employ to ensure that this committee saw amendments first that the government felt comfortable in tabling was breached, again through inadvertence, this morning. I apologize to my colleagues for that minor breach. I would say, however, it was a minor breach.

I am willing to table the three amendments that Ms Lankin referred to. They are all housekeeping amendments; they are not substantive amendments. Again, I apologize that it's back to front, that the media got it first. That hopefully will not happen again. Sometimes individuals in organizations make mistakes, and a mistake was made. There was no wider conspiracy involved. We have no other amendments that are ready to be tabled. This is the extent of the amendments to date that we feel comfortable in tabling with the committee. As soon as there are other amendments to table, we will table them as soon as we can.

Ms Lankin: I'd like to ask for a clarification. You said sometimes people and organizations make mistakes, and I'd like to know whom you're referring to. Are there members of public organizations who have been requesting amendments with whom you have shared your version of amendments and did this inadvertent action come from one of those outside groups, or was it from someone in government?

I am aware as well that there are people in this room who are part of organizations that have been presenting before this committee who are aware of the detail of government amendments that you intend to file before this committee, when I have been asking, for days, to have these amendments tabled so that the broad public would be aware of them and would be able to respond to them in their briefs and so that the opposition, who are madly scrambling to prepare our own amendments, know what the damned bill is that we're trying to amend. What's the final version going to look like?

So I would like some clarification as to how this happened and if in fact there are other organizations that are aware of the amendments that you intend to table.

Mr Clement: If I can respond to that, I believe it was the opposition parties who were urging us to discuss possible amendments to this bill with representative organizations, representative of their particular members, such as the OMA, OHA—I'm not limiting it exclusively to that group. So has the government and has the minister had discussions with them? Yes, we have, and we are proud to acknowledge that.

Ms Lankin: That's not what I asked.

Mr Clement: If I can just respond, Ms Lankin, the process that this government chooses to employ is, as the

government—we're not the whole committee and we acknowledge that—we on the government side who have sat through these hearings have listened very closely to the presenters and are interacting with the Minister of Health and with his ministry to come up with amendments that we feel accurately keep us to the core of what we have to achieve for Ontario, but do it in ways we are comfortable with and the presenters are comfortable with.

I can assure the member that there are no other amendments, that I have reached that stage where we are comfortable with them and the ministry is comfortable with them and the presenters are comfortable with them. As soon as we have that nexus of points of view, we will present them to this committee. We are committed to that and the Minister of Health is committed to that.

The Chair: I believe that's enough discussion on the point of order. Thank you very much, folks.

Our next presenter is Karen Haslam, representing the coalition for social justice.

Interruption.

The Chair: I'm sorry, sir—

Interruption.

The Chair: The committee is recessed.

The committee recessed from 1337 to 1339.

The Chair: The meeting is reconvened.

Mrs Caplan: Mr Chairman.

The Chair: Yes, Mrs Caplan.

Mrs Caplan: I will be brief.

The Chair: Is this on the same point of order?

Mrs Caplan: Yes.

The Chair: I've ruled that point of order is over.

Mrs Caplan: It's on my point of privilege. It's not on the same point of order. I would like to respond to what Mr Clement said.

The Chair: No, that's the same point of privilege and I have ruled on that, Mrs Caplan.

Mrs Caplan: Well, I'd like to speak to a point of privilege. I will be very brief.

The Chair: We are going to hear from these presenters.

Mrs Caplan: Yes, we certainly will, and I will be very brief, but I'd like to be heard.

The Chair: Mrs Caplan, we are going to hear from these presenters.

Mrs Caplan: Mr Chairman, I'm asking for a minute to be heard.

The Chair: No, you're not going to be heard. I'm sorry.

Mr Crozier: What a dictator. I've never heard anything like it. Jack, you were a better guy than that when you started.

The Chair: Mr Crozier, you're out of order.

Mr Crozier: What are you going to do about it? Are you going to kick me out?

The Chair: Karen Haslam, the coalition for social justice, the floor is yours. You have a half-hour of our time to use as you see fit. Questions will begin with the New Democrats.

1340

Mrs Caplan: Your true colours are showing. People are going to see the kind of dictatorial authority you want. The way that you're conducting hearings is an outrage.

Interjection.

Mrs Caplan: Well, then, let me have one minute. Unanimous consent that I can have one minute—

The Chair: There's going to be another five-minute recess.

The committee recessed from 1340 to 1344.

The Chair: Okay, welcome—

Mrs Caplan: Mr Chairman.

The Chair: Yes, Mrs Caplan.

Mrs Caplan: I request unanimous consent to have one minute to address the committee.

The Chair: Is it on the same point of order?

Mrs Caplan: Mr Chairman, I'm making a motion for unanimous consent that I be given one minute to address the committee.

The Chair: Is it on the same point of order?

Mrs Caplan: Mr Chairman, I have the right as a member of this committee to move a motion. My motion is that I ask for unanimous consent to have one minute to address the committee, on whatever matter. I've been told by Mr Clement that they have no objection to that motion.

Mr Clement: But it's the Chair's call.

The Chair: I would ask you to state if it's on the same point of order.

Mrs Caplan: Mr Chairman, I have moved a motion. I'm asking for unanimous consent for one minute to address this committee.

The Chair: Well, Mrs Caplan, I guess you and I are going to differ on this one.

Mrs Caplan: Call for unanimous—say, "Do I hear unanimous consent, yea or nay?"

The Chair: We'll do this whatever way you want. We'll delay the proceedings until you decide to answer my question.

Mrs Caplan: Mr Chairman, as a member of this committee, I have moved a motion, and my motion is that I be given one minute to address the committee. I ask that you, as the Chair of this committee, put the question and say, "Do I have unanimous consent, yea or nay?"

The Chair: Is it on the same point of order?

Mrs Caplan: That motion is in order.

The Chair: Is it on the same point of order?

Mrs Caplan: It is not on a point of order.

The Chair: It's not on the same point of order?

Mrs Caplan: It is not on a point of order.

The Chair: It's not on the same point of order. Okay, Ms Haslam, you have the floor.

Mrs Caplan: Mr Chairman, I have moved a motion and I ask that you call the question. It is appropriate for the Chairman to say, "Do I have unanimous consent to Mrs Caplan's motion to have one minute?"

The Chair: You're going to win this one, aren't you? This is all about the press. Do I have unanimous consent for Ms Caplan's motion?

Mr Clement: Agreed.

Mrs Caplan: Thank you, Mr Chairman. I appreciate that.

What I would like to say is that I accept the apology of the government in the way the amendments were tabled, but I would like them to clarify, for the presenters and those who have had motions shared with them, that

in fact it was not any organization, other than someone within government, that was responsible for the media receiving the package.

Mr Clement: Yes, it was the government's mistake.

Mrs Caplan: Thank you very much.

PERTH COUNTY COALITION FOR SOCIAL JUSTICE

The Chair: Coalition for social justice. You have a half-hour to use as you see fit. Questions will begin with the government.

Ms Karen Haslam: Thank you very much. I must admit it's much more active this afternoon than it was this morning. It's nice to see some life after lunch. My name is Karen Haslam, and I am the vice-chair of the Perth County Coalition for Social Justice. With me is Linda Mackay, who serves on our education and media committee. We'd like to thank you for the opportunity to come here today to express the concerns of the individuals in our organization about this omnibus bill, a bill that will have serious consequences for the quality of life of the citizens of this province.

The Perth County Coalition for Social Justice is a grass-roots organization made up of various individuals and representatives from community associations, such as co-op housing, counselling services, labour and activists in the women's movement. We banded together after we saw what was happening in our community as a result of the election of the Harris government.

Our community's second-stage housing development, the Emily Murphy Centre, which provides abused women and their children with affordable, safe housing and services, was going to have to close its doors due to a cut of \$100,000 to its program budget. Funding to the Stratford-Perth Counselling Centre covering its program for men who abuse was cut.

The mobility bus and taxi funding was cut, resulting in shorter hours of operation and less access for disabled clients. Welfare cuts were resulting in people being evicted from their homes. Demands for subsidized housing increased, yet a co-op housing development for seniors had its funding withdrawn. The library lost funding for computer access to the information highway, the great leveller for anyone, poor or rich, for access to knowledge.

The Stratford Jail was scheduled to close, and family court proceedings may be moved. Jobs will be lost, as well as access to the legal system and protection.

The food bank reported that clients increased by 33% since September, including several new clients as well as old clients who have been forced back into needing help.

This was all before November 28, 1995. Then came the financial statement and more cuts were announced, more attacks on women, children and the disadvantaged. And Bill 26? Just look how it was introduced.

As the Perth County Coalition for Social Justice worked together to formalize our mission statement and outline our concerns, we became increasingly aware that under the Harris government, the general population had little or no input to government decisions. This was not social justice.

1350

What is social justice? The Perth county coalition believes, "Social justice can only exist in a free society in which all people have equal opportunity and full access to the resources needed for their physical, emotional, intellectual and spiritual wellbeing." Our statement of purpose is attached to this brief, but I would like to note number 6, "To take our statement of purpose seriously and insist that others in positions of influence and power fulfil their responsibilities in maintaining Canada's tradition of social justice and protection of the vulnerable in our society." That brings us here.

The Perth County Coalition for Social Justice is calling for the scrapping of this omnibus bill. Primarily we believe Bill 26 attacks our democratic process. It will devastate our public services and impose hardship on our communities, a hardship that will be especially felt by those who are most economically disadvantaged: children, seniors, unemployed workers, the disabled, and persons on assistance, the majority of whom are women-led, single-parent families. The quality of life of essentially everyone in this province will be eroded and the disparity between the haves and have-nots will increase.

As we endeavoured to look into this complex and far-reaching bill, we found out that the compendium provided with Bill 26 ran about 2,200 pages, even though it does not include the full text of all the acts being amended. We also found out that it amends 44 acts. As a fledgling group with little or no money, we couldn't begin to address the myriad of changes or begin to understand the intricate legislative text, but we did understand the unprecedented power it gave to government ministers and the Ontario cabinet and the lack of input, parliamentary debate or public discussion it imposed on the people of our communities.

While we obviously were concerned with the rollback of pay equity for women, the new powers allowing municipalities to impose user fees and poll taxes, losing some of our fundamental rights under the freedom of information act amendments, and environmental short cuts, it is schedules F, G, H and I in the health section of the omnibus bill that we wish to address today.

Firstly, as we understand it, in the health section of Bill 26, the cabinet, Minister of Health, hospital supervisors and boards of directors are protected by the legislation against any liability or court challenges. Yet health care providers and citizens have not been provided with any vehicle to appeal decisions or to provide input to the decision-making process. This is unacceptable.

Some of the most remarkable powers the minister would have revolve around our hospitals. As we understand it, apparently he could close our hospital. He could order amalgamation. He could specify the services to be delivered by our hospital. And all this if he deems it to be in the "public interest."

But what ties in with this is the fact that under a new section, 9.1, the issues to be considered in determining the public interest are defined, yet the minister and cabinet are not limited by these and can consider "any matter they regard as relevant." Included in the list is the availability of financial resources for the management and delivery of the health care system. Bottom line: He could

make decisions about our community's access to a hospital without looking at the health issues at all, just the financial issues. This is unacceptable.

All of this without input from the medical community or the people affected, the public, and as mentioned previously, the minister and cabinet under section 13 are protected from any legal liability from any decisions as a result of their direction or level of funding. This is unacceptable.

As we understand it, Bill 26 repeals the existing preference to Canadian-owned, non-profit health care providers and public tendering. We are not in favour of encouraging American for-profit companies to take over an increasing part of our health care system, eventually leading to the privatization of many of our public institutions.

I would like to read into the record a letter published in the Financial Post on March 11, 1995. It's entitled "Don't Buy Into US Health Care."

"Canadian friends sent me a column by Neville Nankivell (Jan 14-16) that implied some Canadians want a US-style health system.

"As an American and a survivor of this system, let me enlighten those Canadians so inclined.

"I paid Blue Cross and Blue Shield premiums for many years. In 1984, I was diagnosed with cancer and as a result had a kidney removed. This procedure cost me, personally, \$42,000 over and above the amount paid by Blue Cross totalling \$160,000. I then was refused further health insurance due to what was described as a risk factor.

"As a result, I now have no insurance, no job and no money. My only hope is to survive 10 years when, at age 65, I shall be eligible for medicare, which in itself only allows partial coverage.

"Please let the word go out to those Canadians who hearken to the propaganda of the medical lobby, be it in the US or in Canada."

This was signed by Henry Korz, South Padre Island, Texas.

Privatization, coupled with changes to the definition of "facility fee" and the ability of hospitals to charge extra fees, will produce a two-tiered, Americanized health care system. This is unacceptable.

As we understand it, Bill 26 deregulates drug prices. We find it interesting that the government is willing to set aside the BAP, best available price, system now used for pricing drugs in favour of negotiating with the manufacturer but will set the maximum ODB dispensing fee by regulation so it doesn't need to negotiate with pharmacists. The pharmacists have had little or no increase in their fees for a number of years. However, under the federal Bill C-91, the patent on drugs was extended so drug companies could charge the highest price for their medication for a longer period of time. This government actually believes that negotiating with large drug company consortiums is preferred over negotiating with the pharmacists' association. Ontario will become the only province that does not regulate drug prices to keep the costs under control. This is unacceptable.

As we understand it, Bill 26 introduces user fees for seniors and social assistance recipients on the Ontario

drug benefit plan and will no longer pay the difference between the generic and brand-name cost for patients whose doctors recommend no substitution in their prescriptions. Furthermore, given the power the minister will have over doctors, what is a necessary health service will no longer be decided by a doctor but by the Minister of Health, who is defining all of this based on financial resources rather than on any medical criteria. This is unacceptable.

One of the most damning sections is the new section 29. As we understand it, this section gives the minister and the general manager of OHIP the power to collect and disclose patient information. Patients are deemed to have given their consent for the collection of information, and as previously mentioned, the minister and general manager have immunity from any prosecution as a result of any disclosure. This is unacceptable.

There are many other substantial changes in this omnibus bill, but no sector is as significantly affected by Bill 26 as the health sector. Medicare as we know it is under attack. Privatization and corporate profits have now taken precedence over the health of our communities. This is unacceptable.

Attacks on the elderly, the poor, women and children and the disadvantaged in our society through extra-billing and a two-tier medical system is unacceptable.

The Perth County Coalition for Social Justice does not feel that adequate time has been given to the public, indeed to the members of Parliament themselves, to review this monumental piece of legislation. In watching the beginning of this committee's meetings on the parliamentary channel, I was intrigued that not even the Minister of Health himself was able to answer questions regarding certain aspects of this bill put to him by Ms Lankin.

The public interest is ostensibly the reason legislators pass laws and are elected to govern our province. It is our contention that the public interest would not be well served by the proposals in this omnibus bill. Accordingly, we add our voices to those who are calling for the withdrawal of Bill 26.

1400

Mrs Ecker: Thank you very much for taking the time to come and present, and a particular welcome to Ms Haslam. The committee has had close to eight or 10 presentations from previous MPPs now engaged in other careers. Welcome to the committee, and I very much appreciate your comments.

The quote you've used from the newspaper in the States is an excellent example of the kind of health care system that—if there is one thing Canadians and those in Ontario agree on, it's that we don't want the American health care system. But we've also heard from these committee hearings that the system in Ontario, as it currently stands, needs to be reformed, needs to be changed. We've heard some very eloquent presentations from communities who argue that there is indeed a two-tier health system there now: those who have physicians and those who are not able to have physicians. We've heard about overprescribing. We've heard about the need for guidelines. There have been lots of examples of why the system needs to be reformed, and that is something

that the government, as you know, is trying to respond to and trying to make those changes.

You raised a couple of questions in your presentation. I can certainly appreciate, as a community group, your point about not having resources to do legal analysis of legislation. I would like to suggest that in terms of the minister's power to prescribe information, to collect information, to make agreements and arrangements about information collected in the health care system, there are different but similar powers in the current Health Insurance Act. One of the fundamental principles of the system is doctor-patient confidentiality, and we certainly appreciate that. That's one of the reasons we've been willing to sit down with the privacy commissioner and work out ways to ensure that that principle—we believe it is still there, but we want to ensure that those who have expressed concern about it see it as being still in the system.

The other point you made was the concern about who was deciding what was medically necessary. Again, in the current Health Insurance Act, in order to go after potential misuse in the system, the general manager of OHIP does have grounds to make what are considered "medically necessary" decisions which are made with reference to the Medical Review Committee. Most physicians who've come forward have said that process is something they would like to continue to see, that they'd like to see that use of information stay under the Medical Review Committee. We've certainly been prepared to entertain suggestions and amendments to make that system work better, because the organization that runs it currently, the college, has expressed some concerns about the way it is being run and we've been willing to make some changes there.

The other reason it's been important to try and have access to information, while at the same time making sure we're protecting patient confidentiality, is the use by some consumers of the system. For example, in one month over 7,000 individuals used five or more family physicians, which most people agree is an overuse of the system. The way we were able to track that is to use something like smart cards or other technology. Again, that is a need for patient information.

I know it's something your government wrestled with, misuse within the system, and there's always a debate about how much is there and whatever. How would you suggest we continue to go after misuse in the system by whomever, while at the same time protecting the confidentiality of patients, which we all agree is—

The Chair: Unfortunately, Mrs Ecker, your question's just a little too long.

Mr Crozier: Thank you for your presentation. It's nice to see you again. You said in the first part of your brief that, "The Emily Murphy Centre, which provides for abused women and their children with affordable, safe housing and services, was going to have to close its doors due to a cut of \$100,000 in their program budget." The minister responsible for women's issues—I would be paraphrasing—has essentially said in the Legislature when it's been brought to her attention that this has happened, that these halfway houses are under a threat of closing, "No, they're still there; we haven't closed any of

those houses." But you would be able to explain to us what may ultimately happen, that they may be right that they're not be physically closed, or that the government may not physically close them, but it will amount to that.

Ms Haslam: I must point out that this situation was probably the most lightning-rod thing in our community that brought us together. This was the beginning of the women in the community having an open, public forum and talking about some of the changes coming and some of the effects of those changes.

Ms Mackay works at Optimism Place, another battered women's shelter. This Emily Murphy Centre is the second phase. That means longer periods of time when mothers escaping abusive situations go into a building and are secure in that building. What was happening was that they were losing the additional counselling services and programs for their children, for themselves, for their self-esteem. It was becoming a shell of a building where they were being ghettoized, having this second-phase housing to go to that was supposed to be very secure and it didn't offer anything for them.

As a matter of fact, in this situation, because they share funding with the Ontario Ministry of Housing and the Ontario Ministry of Health, the Ministry of Health was withdrawing its support and it affected some of the joint things they were able to put into the building for security. For instance, they were being requested to sell off their computer system, to sell off the monitors for the cameras in the building, so what they had was a secure system without any way of making it secure. They had the cameras, but no monitors. They lost a staff person to help monitor what wasn't there anymore. They lost the services for the children to have a self-esteem program. They lost the services of a staff member to go with these women to court, to be with those women, to support those women when they were going through difficult times in the court system. What they lost were the services in that building, and it become an empty shell building with no services.

Ms Linda Mackay: I'd just like to add that there's been no commitment whatsoever. The building exists. Women can live there. They have absolutely no security. They have no guarantee of how long they can live there. They're there in a risky situation without staff, security implemented, let alone the programming.

Ms Lankin: Thank you very much, Karen and Ms Mackay. It's a pleasure to see you here. We appreciate the presentation from the coalition. You might have gathered, having watched, that I'm a little perturbed about the situation and not being able to get amendments and to know exactly what's going to be changed. Ms Ecker just told you that essentially the powers to gather and review and disclose information by the minister or the general manager were already there in the old bill. "They're different but they were already there," I think were her words. In fact, they were very different. There was no such thing as the clause in there now in 21(1)(d), which says the minister can prescribe any other purposes for which he can gather, review and disclose that information. It's extraordinary.

I've been hearing for a week and a half that they've been meeting with and talking to the privacy commis-

sioner and are going to make amendments. The privacy commissioner presented before this committee in the week of December 18, the first week of hearings. They've had over a month to get this done. Where are they? Why can't we see them? Why couldn't you focus on other issues today in your presentation and not have to worry about that?

On the issue of medical necessity, again Ms Ecker glosses over the nature of the change, which takes it from the general manager having reasonable grounds to think there might be a question around medical necessity and sending it to peer review, to doctors in the medical review committee to look at and decide, to the decision being made by a bureaucrat. They say they're going to do something that might fix it and put it back to the old way. I'd like to see those amendments.

1410

I wanted to ask you about your concern around medicare, universality, the two-tiered system. We heard from a bioethicist who said this act fundamentally allows the system to be changed, to move in the directions you talk about—whether the government does it or not, we don't know; it's a blank cheque and they haven't filled the number in yet—and that there hasn't been the debate, and the values of medicare are among the core values of Canadian society. Can you comment on how you feel about that?

Ms Haslam: The underlying issue here for us as a grass-roots organization is process and our chance for public input and public interest, which—you're absolutely right—is medicare at the core. Our concern is the unprecedented powers that are given without any opportunity for redress and without any input from those of us in small rural communities. Stratford is in the middle of a very rural area, a small community. We have little access to have our input into the decisions. There are too many powers in that.

When you mention a two-tiered system already being there, I'm talking about a two-tiered system where there is a doctor present and we still can't access the health care. There are people in our group who can't afford the user fees, who can't afford the possibility of a user fee in the hospital for the food and accommodation and the other issues. That's a two-tiered system.

To me, a two-tiered system is not in the north where there is only one doctor instead of three. A two-tiered system to those we represent is that even given we have a doctor, even given we have the prescribed number of doctors in our county, the two-tiered system this becomes open to is that we still can't access it. It has taken away the universality of the health care.

I'm not fully cognizant of many of the reports out there, but it has always been my understanding that there are surveys and studies that have shown that user fees do not effectively solve the problem about access to the medical system and only hurt those at the lower tier. If I'm wrong, you can correct me.

Ms Lankin: No, you're absolutely right.

Ms Haslam: For me, public input and public interest is where we are very concerned in this bill.

The Chair: Thank you very much for your presentation this afternoon. We appreciate your interest.

CANADIAN AUTO WORKERS, LOCAL 1986

The Chair: The next presenter is the Canadian Auto Workers, Local 1986. Good afternoon, and welcome.

Mr Don McFarlane: Good afternoon. My name's Don McFarlane, vice-president of Local 1986. I'd like to thank the committee for allowing me the opportunity to be here today. Currently, I'm a benefits representative for the A.G. Simpson chain, which has 2,200 members, as well as vice-president of CAW Local 1986 in Cambridge, which covers another 2,000 members.

I must say in opening that the contents and undemocratic process by which this Bill 26 has been forced upon us is, in the lightest terms, disgusting. When before in the history of Ontario politics has the public been denied a fair and democratic right to appear before a travelling committee such as this? I'm making reference to the number of individuals or groups who have been denied standing at these hearings.

I am here today not as an expert on the health care system but as a concerned citizen and a representative. My concerns are based on what I perceive to be the Americanization of our health care system, a system designed for the rich, and on the other tier will provide little or no affordable services for the working poor, unemployed, underemployed, welfare recipients, students, elderly and single parents. How heartless of a government to decide that life isn't hard enough. Now these above-mentioned individuals will be asked to pay user fees and asked further to line the pockets of the multinational drug companies, asked to shop for a hospital or a for-profit clinic that will service them. All this, but don't ask any questions, because even the right to appeal by a health care provider or a citizen will be destroyed by Bill 26.

Let's look at the changes to schedule F. Schedule F amends the Ministry of Health Act, the Public Hospitals Act, the Private Hospitals Act and the Independent Health Facilities Act.

Ministry of Health Act: Bill 26 creates a hospital services restructuring commission that will implement the government's agenda on hospital restructuring. This commission is totally protected from any liabilities surrounding said restructuring. Gone is any reference to district health councils in section 8 of the Ministry of Health Act.

Public Hospitals Act: Bill 26 gives the minister total unlimited power to dictate how hospitals are funded, operated, closed or amalgamated.

Private Hospitals Act: The minister has the power to close or terminate any grant of any private hospital without notice. Repealed is the right to appeal. Also, the minister is protected against liability.

Independent Health Facilities Act: Bill 26 repeals current language in this act under subsection 6(3). In this section, it directs the minister to give preference to non-profit Canadian operators. Under the repealed language, the minister can direct that proposals be limited to one or more specific persons. Does this open the door to for-profit American health care providers?

Schedule G amends the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act, 1991.

Bill 26 introduces copayments and deductibles for seniors and social assistance recipients. It also deregulates prescription drug prices, and this certainly puts Ontario on the map as the only province that does not regulate prices. The Ontario drug benefit user fee or copayment will come into effect June 1, 1996. Dispensing fees will now be regulated unilaterally by the cabinet. The past process allowed for these fees to be negotiated between the government and the Ontario Pharmacists' Association. Bill 26 also gives the minister the unilateral right to determine which drugs will be listed and delisted. No longer will the markup on drugs be restricted to the 10% to 20% mark, as it is now. The markup will be set by regulation.

The minister has the power to override the decision of the doctor or pharmacist as to what is suitable medication, leaving the individual to bear the cost between approved drugs and prescription drugs. All these changes are magnified by other sources; for example, federal changes to the patent protection of Bill C-91. If you expect us to believe that deregulating drug prices is going to make the price go down, forget it. As we stated in our fight-back campaign against C-91, there were alternatives—such measures as control of overprescribing by doctors, and to control the high costs and profits of multinational drug companies. Gone is the healthy competition of generic drugs and open is the market for wider profits. But whom does this affect? By far seniors and welfare recipients are going to feel the biggest effects. But what about those fortunate enough to have a job with insurance plans? The changes to Bill 26 will have a definite effect on premium increases, which in turn mean higher costs to the employers as well as the employees.

Schedule H, Amendments to the Health Insurance Act and the Health Care Accessibility Act: Bill 26 removes reference to medically necessary services and installs the power to the cabinet to decide what services will be insured. The cabinet has the power to determine the type of services provided to persons in prescribed age groups. It gives cabinet power to unilaterally establish basic fees payable for insured services. One amendment to the Health Care Accessibility Act gives cabinet the power to make regulations that would permit hospitals to charge patients user fees for any hospital services.

Schedule I: The Physician Services Delivery Management Act strips the Ontario Medical Association of any negotiating rights and says judges' ruling decisions, awards or orders shall be of no force or effect.

1420

Schedule J, Amendments to the Pay Equity Act: Effective January 1, 1997, Bill 26 repeals the proxy provision for an estimated 100,000 low-paid women in such areas as nursing homes and day care who work for employers with no dominant male job classes. They will have their right to fair pay abolished. It is obvious that this government feels their support was derived from the male population of this province only. Congratulations.

Schedule K, Amendments to the Freedom of Information and Protection of Privacy Act: It will be harder to gain access to documents. Institutions will be able to deny access on the grounds that the request is frivolous

or vexatious. It will be easier to dismiss appeals when access is denied. New user fees will be introduced, starting with an application fee and an appeal fee, both to be set by regulation. The first two hours of search time will no longer be free. This amount of the fee will be set by regulation, as well.

Tom Wright, the Information and Privacy Commissioner, says the measures would threaten the fundamental right of people to know what is happening in their government. He says the new fees may deter people from seeking out information.

Mike Harris talked about democracy. If Bill 26 represents the vision of democracy maybe we should replace the trillium with a sickle or even build a wall around this once-proud province. The bill only represents power, power for the government and for corporations of Ontario. Perhaps congratulations are in order for giving the people of Ontario a reason to fight, as this bill will affect every household in Ontario.

As a representative I would like to again file my disgust. What this bill will do to our members in relation to their work is take pay increases out of their pockets and we'll have to use them to cover the increased premiums of insurance plans this bill is sure to bring. Thank you.

Mrs Caplan: Yes, thank you very much. You've raised, at the very beginning of your discussion paper, which was very thoughtful and very passionate, the issue of Americanization and you raised that issue in the context of the move to two-tier, the potential of which of course is there with the aspect of hospital user fees. Although the drug plan formally isn't under the Canada Health Act, we now will have two-tier for those who are covered under the Ontario drug benefit plan. There's a very definite two-tier, one paying a copayment, one paying a deductible, no question about it. That's a slippery slope and I think that's what you were alluding to.

While this government has said that it is going to adhere to the Canada Health Act, we do see some very significant Americanization. I'm going to read you a quote from a New York Times article on January 15: "'They are basically moving to a US managed-care model,' said Peter Coyte, professor of health administration at the University of Toronto. 'The rigid protocols of American managed care intended to check the rising costs, clash with the underlying principle of the Canadian system that the doctor alone should decide what is appropriate for an individual.'" That statement was made by a University of Toronto professor.

What we see is indeed that this government, with Bill 26, if you take certain parts of it and put it together, will have the power to bring in US managed-care organization and they will be able to do that with the power of cabinet setting what is a medically necessary service. Just as you have preauthorization in the United States, that will give the power to the minister to do that, with the added ability to share information and disclose for any other purpose, which is new in this legislation, those in combination will allow the Ontario Ministry of Health to start behaving like a US insurance company with their managed-care organization catch to it.

I wondered whether you had realized, when you talked about the Americanization of the system, that that was possible as a result of this legislation.

Mr McFarlane: As I said, I'm certainly no expert, but I have my visions and I would certainly share some of those visions that this is possible.

Mrs Caplan: The concern I have is that this isn't being presented as health legislation; this is treasury policy, fiscal legislation, carried by the Finance minister. We have nobody here carrying the legislation from the Ministry of Health, and we are seeing potentially fundamental change and Americanization of Ontario health care. That's one of the reasons that I am so tremendously frustrated, particularly when I hear people such as yourself coming here and talking about their fears. Thank you very much.

Ms Lankin: Mr Chair, just on that point, I tabled a series of questions last week—you may remember them, because you were a little perturbed that I had so many of them—with respect to health management organizations, and actually there were some other questions over the course of the week that I tabled and that Mrs McLeod tabled. We've not received answers to any of them. I'd point out there are only two days of public hearings left.

I wanted to talk to you about the concern you raised on process, of how this is all being done and the powers being taken into government and no public input and things done by regulation. I want to give you an example. It's not like there aren't other pieces of legislation that allow regulations to be made, but it's a question of how the government will use it. We've heard a lot from this government that it would never abuse this new power it's taking on to itself.

This morning in Toronto the Environmental Commissioner urged the government not to weaken the environmental bill of rights and alleges that it has done that very significantly by a regulation that it passed behind closed doors in cabinet, regulation 482/95; no public debate. She points out that this is a blow to the province's most significant and far-reaching legislation in that area. The timing of this regulation was concurrent with the tabling of the fiscal and economic statement announced by Finance minister Ernie Eves as well as the first reading of Bill 26, the Savings and Restructuring Act. They all occurred on the same day. This regulation exempts the Ministry of Finance from the environmental bill of rights, temporarily suspends specific public notice requirements for environmentally significant proposals for the next 10 months and violates the spirit and the intent of the environmental bill of rights.

There's a lot more material here, but it shows you what can happen behind closed doors, that none of us knew about. Thank God someone has brought it to our attention. Can you talk about how you feel, as a member of the public, about the process of how laws are made and what government should be doing in public with consultation versus behind closed doors in the cabinet room?

Mr McFarlane: Well, specifically to this bill, it's so massive, I really understand how many people still in Ontario, even as we skim the surface here, understand what's behind all this and what motives there are in

giving the power. You're correct. I think, in preparing this and looking at how massive it is, it would have been better served to carve pieces of this out and take committees on certain aspects of this around so the public could have a true input on it rather than try to, even myself, grasp enough information that I could prepare anything to be here today.

Ms Lankin: Okay, I appreciate that. Thank you.

Mr Clement: Thank you for your presentation. I mean no disrespect when I say it's important for us to hear those views. I'm not sure we share entirely all the points you've made, but it's important that the government continue to be exposed to differing points of view, and I thank you for doing that this afternoon.

I have one general question and one specific question. The general question is that—you've been very eloquent about how you wish us to steer away from the development of a two-tier medical system. I made a point earlier—you may not have been in the room at this point—that in a sense we've got some elements, which I think are negative elements but some elements none the less, of two-tier health care delivery in Ontario already. For instance, some communities have doctors and others don't have any access to doctors. Some people don't have the discomfort associated with waiting in line for medical services; other hospitals and other health care providers in our system have long, long queues of days, weeks, months of waiting in line for health care delivery. So that's the problem with the status quo I guess is what I'm saying. Do you buy into that, or am I going off on the wrong track?

Mr McFarlane: For me personally, I would agree with the previous speaker on what "two-tier" means and what it means to the average public citizen who may at some point not be able to afford, whether it's a prescription, whether it's services because of fees. Those are the sorts of tiers I'm talking about that fees are going to install.

Mr Clement: We've got a difference of definition, but I appreciate your point. Can I ask you a specific question? You may not have an answer, but I guess I wanted to relay something to you when you talked about the need for healthy competition of generic drugs.

We do have a provision in the bill relating to Ontario drug benefit recipients. It's called "no substitutions." Where the doctor usually wrote on it "no substitutions" you had to deliver the brand-name drug to this patient, and even if there were comparable and chemically identical generic drugs available, we the taxpayers, we the community, paid for the brand-name drug being provided.

We've severely restricted the ability of that activity to take place. Is that something in line that you would agree with?

Mr McFarlane: I would support generic drugs. As I said, I talk about healthy competition. Without the competition, now that the market's wide open, where are the controls? It's unregulated. There's no control to say: "Okay, we can only have 10% to 20% now that it's wide open. There you go, multinationals. Walk into Ontario. It's a great market; lots of profits. Come and get our poor."

Mr Clement: I just want to make sure I understand. Do you agree with our position on no substitutions?

Mr McFarlane: No, I don't. My point is that I agree with generic drugs, end of question. I agree that is needed for healthy competition and it's also accessible to people who can't afford the brand-name drugs.

Mr Clement: I agree. Thank you.

The Chair: Thank you. We appreciate your presentation here today.

The next group is the Canadian Bar Association, Health Law Section, represented by Tracey Tremayne-Lloyd, the former chair. Not here?

The Region of Waterloo Pharmacists' Association?

Mrs Caplan: Perhaps you could see if any of the other presenters are here at this time.

The Chair: Guelph Wellington Coalition for Social Justice? Sheila Richardson? Ontario Health Coalition? Ontario Health Record Association?

Maybe we'll just recess until somebody shows up.

The committee recessed from 1432 to 1451.

REGION OF WATERLOO PHARMACISTS' ASSOCIATION

The Chair: The Region of Waterloo Pharmacists' Association has arrived a bit early, so we can get back to work. Welcome to our committee.

Mr John Ibbotson: Mr Chairman and members of the committee, good afternoon. I am a community pharmacist at Hoeglers, an independent pharmacy in Kitchener, and currently president of the Region of Waterloo Pharmacists' Association. With me is Sherry Peister, my right-hand person. Sherry is a pharmacist with Shoppers Drug Mart in Waterloo and current past president of the Ontario Pharmacists' Association, as well as past president of this association. We are pleased to be here today to express our thoughts on Bill 26.

Our local association is made up of 75 community pharmacies and represents approximately 200 community and hospital pharmacists in the region. The association currently organizes continuing education events for local pharmacists and keeps our membership current on events happening in the region.

We have successfully worked in partnership with the Waterloo regional community health department and have jointly launched a pharmacist-manned telephone information line for seniors. This line provides information concerning over-the-counter medication and clears up any confusion and questions regarding appropriate medication use to seniors.

We have also worked in partnership with local employers and benefit consultants over the last few years to help them in addressing their concerns over rising health care costs. We always try to address the issues and provide some guidance.

We also worked successfully with the University of Waterloo to develop therapeutic guidelines for rational prescribing, a customized formulary with an exception process, all prior to the Ministry of Health's interest in developing therapeutic guidelines.

The association has also promoted wellness programs and spoken at many of the local workplaces on various topics. We correspond frequently with the physicians in our area over cost issues of drugs as well as other topics

we feel need to be discussed. Our association has successfully used the approach that by working together with other health professionals and listening to each others' concerns, this has enabled us to find solutions that benefit everyone.

We were quite dismayed to find this government trying to push forth such an all-encompassing bill without thorough consultation with all parties involved. We are also concerned that this legislation will put the power of change into the regulations, thereby circumventing the current system and allowing cabinet to unilaterally make and implement change. We do, however, applaud this government in its commitment to cut costs and in holding these public hearings.

Our association would like to address three major issues contained within Bill 26 which directly affect our profession and our membership. They are: (1) deregulation of drug pricing; (2) the loss of our negotiating voice; and (3) the issue of copayments.

First, deregulation: In 1986 the government of the day legislated acts 54 and 55, and thus was born the concept of best available price, commonly referred to as BAP. I will briefly describe the concept of BAP.

Prior to the introduction of acts 54 and 55, there was a spread on drug acquisition cost dependent on your volume-buying power. In most business environments this is a healthy and accepted business practice. Not so in the health care sector, since the commodity being purchased is medication, which affects the wellbeing of all residents in the province. Large corporations could purchase drugs at a lower acquisition than smaller independent pharmacies. BAP was put into place so that the price to the customer would remain the same whether you purchased the drug from a chain drug store in downtown Toronto or from a corner independent in Thunder Bay. This act was put in place to protect the public when purchasing prescription medication.

BAP is based upon the lowest cost of that drug in the largest quantity available directly from the manufacturer at the time that the Ministry of Health releases the ODB formulary. The ODB formulary contains approximately 2,100 prescription medications, including some specialized over-the-counter, non-prescription products. The cost of a formulary drug is defined as BAP plus 10%. The 10% margin is to cover such costs as medication which cannot be purchased directly from the manufacturer and therefore goes through a wholesaler, some drugs whose price per unit is not the same for small and large sizes, and some drugs which are purchased in smaller quantities for safety reasons, such as narcotics.

As you can see, the regulation of drug pricing is quite complicated. The government intends to keep the regulation of pricing within the ODB market and deregulate the rest of the market. It is apparent that the government does not believe free market competition among the manufacturers will ensure competitive pricing of products.

Manufacturers have always wanted acquisition cost rather than best available price. This would allow them to produce smaller quantities and charge higher prices per unit due to packaging. This practice is already in place. For an example, we can quote Zovirax. The Zovirax ointment in a four-gram tube costs \$13.75, for a unit cost

of \$3.44 per gram. Buying it in a 15-gram tube is \$36.70, which is \$2.45 per gram. If you buy Zovirax in the 30-gram tube, it's \$68.65, for \$2.29 per gram.

Conversely, best available price encourages pharmacies to purchase larger quantities and have them on hand to fill your prescriptions. If acquisition cost was in place, pharmacists could purchase supplies as they needed them, not keep them in stock and not have them immediately available for use by the consumer. As well, this cost would be more expensive to the consumer since the smaller, more expensive packaging would be purchased.

We also wish to give another example of how the market fluctuates. This is an example from 1990. At that time a drug called methotrexate was available for cancer patients. A side-effect of the drug was that it proved to be a breakthrough for treatment of rheumatoid arthritis. The manufacturer applied for a new indication of the drug. They repackaged, renamed and repriced the drug from \$55 to \$100.53, which is almost a 100% price increase. A public outcry from pharmacists, physicians and patients using the drug successfully brought pressure upon the manufacturer to reduce their price. Ironically, this drug continued to be available to hospitals at the reduced cost and to retail pharmacies at the higher cost during the first few months of entry in the marketplace.

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The proposed legislation leads us to ponder if similar comparisons will be drawn between the ODB program and the private sector. Drug prices could vary between chains and independent pharmacies, consumers living in various parts of the province, and between those who participate in the ODB program and those who pay cash.

A letter recently went out to manufacturers from the Ministry of Health for a price freeze this year on their products. Mestinon 60 mg was available for purchase in December 1995 for \$14.91, and in January 1996 the price went to \$42.95, direct from the manufacturer. When we see these types of drug increases in a regulated market, we are concerned about the impact on our patients if pricing is not kept regulated. Since our association's commitment to patient care is forefront, our position to the government is to maintain the current standard of regulation of drug costs and the BAP plus 10% concept.

Second, negotiations: As stated previously, we believe that by listening to each other and working cooperatively together, we can be quite successful in our achievements. To this end, we were quite disappointed and disillusioned with the Ministry of Health, in finding that Bill 26 effectively eliminates the negotiation process now legislated between the Ministry of Health and the Ontario Pharmacists' Association.

In a letter to every pharmacist in the province of Ontario dated July 5, 1993, Minister Wilson, then the Health critic for the Conservative Party, stated strongly that they would not support a bill, Bill 29 at that time, that enabled the government to end-run the current fee negotiating process. We have an appendix at the end if you would like to refer to that later.

We have never negotiated with the Conservative government and find it hard to believe that they would eliminate a process which they have never participated in, albeit a poor one that is without binding arbitration. The

elimination of the legislation will leave pharmacy at a complete loss to discuss remuneration for services, since pharmacy would find themselves in violation of the Competition Act.

Such services that pharmacy is currently looking at are trial prescription programs, such as the one that is now operating in British Columbia; payment for not dispensing prescriptions—there's a program in Quebec at this time; payment for cognitive services—this is also a Quebec program; therapeutic interchange, which would be a private sector initiative; and therapeutic guidelines.

The trial prescription program in British Columbia currently under way suggests from data collected and collated that significant cost savings are achievable. Results currently show that 57% of prescriptions filled were not renewed after the first trial portion was dispensed. This cooperative effort between the Ministry of Health in British Columbia and the British Columbia Pharmacists' Association has shown how an innovative program can successfully save the government money. Anyone wishing to have further information on this program should contact the Ontario Pharmacists' Association for a copy of the project.

British Columbia has also recently implemented a program similar to Quebec's where pharmacists are paid a professional fee not to dispense a prescription. Pharmaceutical opinion in Quebec reimburses pharmacists not to dispense and for a schedule of other interventions, including irrational choice of a product. The Ontario Pharmacists' Association would also be happy to provide this document upon request.

Implementation of any or all of the above can result in savings within the ODB program. We have seen these effective models already in place in other jurisdictions. We believe that pharmacy should be remunerated for the services provided at a level that is fair and reflects the level of service received by our patients. The issue of payment for services and other changes occurring in the managed care environment must be addressed by the government. The Region of Waterloo Pharmacists' Association would like the government to keep the Ontario Pharmacists' Association as the negotiating voice for pharmacy and to work on a process that is fair and equitable to both parties.

Third, copayment: Copayments or user fees have always been a contentious issue. Does implementing such create an awareness of or a responsibility for drug usage, or does it cause undue hardship to those who can least afford to pay? We do not question the need to control the spiralling ODB program expenditures to help maintain the program's viability. We support this initiative.

The recommendation as set out in Bill 26 to collect a \$2 or a \$6.11 copayment based on income levels seems complicated and appears to be in violation of the patient's right to confidentiality at the pharmacy counter. In the Common Sense Revolution Premier Mike Harris states that no user fees will be implemented and that a new fair share health care levy may be introduced. As our association has heard nothing concerning this fair share health care levy, we would like to see this concept explored further before the government implements a copayment schedule as set out in the legislation.

We would also like to explore the possibility of a consumption tax rather than the proposed copayment for participants of the ODB program. A 2% tax could be collected at the point of sale in a pharmacy and collected on behalf of the government in the same manner as the GST and PST.

We feel that there is still much investigation and thought to go into other means of potential cost-saving measures before the implementation of a user fee. For this reason, the Region of Waterloo Pharmacists' Association cannot support copayment as set out in Bill 26.

We thank you for the opportunity of presenting this brief to you today. We truly believe that by working together and by government listening to the voice of the people workable solutions can be found, palatable to all those involved. Rational medication use, reduction in medication waste by reducing quantities dispensed, pharmacists' interventions with appropriate remuneration and implementation of pharmaceutical care are approaches that will save the government money without hindering patient care. Thank you, gentlemen and ladies.

Ms Lankin: Thank you. I want to ask you about the deregulation of drug prices and the best available price plus 10% concept, that whole area you addressed.

We have heard very differing views of what this will mean. The brand-name pharmaceutical industry says that it will bring drug prices down. The generic say they're not sure: they don't think it'll bring it down, but they can't say for sure if it'll make them go up. A lot of consumers believe they will go up. The pharmacists' association thinks prices will go up. London Life said that in the short term, three to five years for sure, they'll go up and maybe after large benefit companies like them have tools, they'll be able to monitor it. Rx Plus this morning said it'll bring it down. I've admitted this on a number of occasions, but I am quite confused.

The pharmaceutical industry says that transparent pricing policies, which show not just the dispensing fee but the markup of pharmacists and the base cost of the drug, would allow consumers to drive competition which would bring the price down. Could you comment on that? Does that solve the problem from your point of view?

Mr Ibbotson: Sherry might like to comment on that.
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Ms Sherry Peister: I think it's an issue that's confusing to everyone. I know that the London Life article about the prices going up in the short term was in the paper this morning. It's hard for anyone to actually say what's going to happen to the pricing market at this time. We can only just—I hate to use the word “speculate,” but that's really what you have to do.

But we can see that when the deregulation happens, what happens to that, as we've stated in the brief, is that larger-volume-buying groups such as the large chains will be able to purchase the drugs for a lower cost. We feel that independent pharmacies, some of them up north in Thunder Bay or Sudbury, may not be able to purchase that drug at that same price.

We also think that the manufacturers could charge an extra distribution charge and as well—it's both counts: pharmacies as well as manufacturers. Pharmacies that are in locations where there's only one pharmacy may also

charge the extra burden on to the customer, so that the customer in the north of the province or in a town where there's only one pharmacy may be hindered by that deregulation of the price.

Ms Lankin: In terms of the ability of small or independent pharmacists to purchase the drug at the same discount volume that a large chain could, it was pointed out, I think, by one of the presenters or in one of the briefs that small independents had the opportunity to buy through the Drug Trading Co of the OPA. I don't know what that is, but it's like a cooperative buying, I guess. Will that solve the problem and is that accessible to all independent pharmacies and can we be assured that it will put them on an equal footing with the Shoppers etc?

Ms Peister: I don't think so, because currently Drug Trading purchases drugs for that group of independents. They go under the Guardian and the IDA banners, that part of the Drug Trading Co group, which are shareholders in the company. It actually works as a wholesaler, so the Drug Trading Co purchases drugs from manufacturers and then passes them on, so there's an upcharge in there as well. Whether they can buy it cheaply, I don't know. There are products on the market right now in the formulary where big chains like Big V, which has the largest buying power in the province, cannot purchase a drug for the best available price currently.

Ms Lankin: A last quick question: In some of the historical newspaper articles we read about people driving all the way from Hamilton to Toronto, to Honest Ed's, to be able to get good drug prices. Is there any reason to think that competition wouldn't recreate that situation of big-volume stores and people having to travel long distances to be able to afford cheap prices on drugs?

Ms Peister: It may happen. We have seniors who go on outings, on a bus trip, to go and get something, so they may go ahead and look for a lower price. But I think it's going to be an awful burden on the patient that they are going to have to phone five, 10, 15 different drugstores to find out what the price is at different drugstores, what the fee is at different drugstores. "Are you going to charge me the copayment? Are you not going to charge me the copayment?" I think it just becomes such a complicated issue, and obviously we wonder, how can the ministry regulate within the ODB program for the same drugs that are going to be deregulated out in the marketplace? I think it's just creating a lot of confusion, and we really wonder how it's going to be handled.

Mrs Johns: Thank you very much for your presentation. We've heard from a number of pharmacists and we appreciate the input we're getting, a little different view every time. I just wanted to ask you a couple of questions. My dispensing fees: I notice them when I get drugs for my kids, for example, very much across where I buy my drugs. Can you comment on why that happens, that the dispensing fees are in such a different range?

Ms Peister: We like to refer to our dispensing fees as professional fees, because they're for the professional service that we render. I think a lot has to be taken into account—location of a pharmacy, what overhead costs that they have, whether they're renting or if they own, the type of labour they have involved in the store. It's all a

business attitude of what you can afford to get a markup on your drugs, because we are in the health care business but we're also in business to make a profit. That's why dispensing fees are different. There are some people who can operate on a lower margin. Smaller independents need a larger margin to be able to provide that level of service.

Mr Ibbotson: And does the pharmacy deliver?

Mrs Johns: No. But that's okay. I understand.

Mr Ibbotson: There are all kinds of services offered in that fee.

Mrs Johns: I understand that they can vary—we've heard quotes and articles in the ministry—from \$1.99 to \$16 or \$18. Is that not the force of the market that pushes the price down? Would that not be the same force that would be pushing the price of the drugs down also? What's the difference between the deregulation in the dispensing fee versus the deregulation in the drug cost?

Mr Ibbotson: No, because the manufacturer doesn't compete with the public to sell his products. All he has to do is get a doctor to write his prescription. It's a different marketing force.

Mrs Johns: If there was only one product that could serve that need, correct?

Mr Ibbotson: A lot of drugs are only single-source products.

Mrs Johns: There are lots of generics that fulfil the need of—

Mr Ibbotson: Not for 20 years for the new ones.

Mr Gary L. Leadston (Kitchener-Wilmot): I value your professional opinion in terms of the initiative with the government in Quebec with regard to the sampling. I'm not sure whether it's called a program or sampling prescription.

Ms Peister: The trial prescription program.

Mr Leadston: Yes. I'm interested in your opinion with respect to a plan of a similar nature being introduced in Ontario. Do you see that as a benefit to the citizens?

Ms Peister: I think it would be a major benefit. We've been dealing with the ECHO group in the private sector, and ECHO is interested in running in some of their companies a trial prescription program. It's been very successful in British Columbia. Up in Timmins they call it the Timmins project, and I'm sure you've already heard about that earlier this week or last week. They have been successful in giving a seven-to-10-day supply on a new medication to a patient, and if it's needed again, if they have no side-effects, if their liver enzyme tests come back properly, they fill the rest of the prescription.

In British Columbia they've already had studies coming in that 57% of the prescriptions that were filled as a trial prescription have not come back for repeats because they've had drug interactions with something else, a food allergy, drug allergy or they just couldn't tolerate the medication. We think it would show significant savings in the marketplace.

Mr Crozier: Thank you for taking the time to make your presentation. There has been a lot said. We've had various independent drug firms appear before us. You raised a good question: Why should it be regulated within the Ontario drug plan and not outside? My concern goes further in that there are people—the working poor and

those not covered by a drug benefit plan—whom we have to take into consideration in these instances. In fact, there are those who are covered by drug benefit plans but we have to be concerned about what costs do to their premiums. There's a wide scope we have to be concerned about when it comes to regulation.

If it were to be deregulated and we were to assume that prices would increase, it's been suggested by various people, "Then you can shop around for the best price." I mention that because I want to get to this point. My wife, for example, insists that we go to the same drugstore all the time because the pharmacist knows us, knows those prescriptions we have been using. If we were encouraged to shop around and if our druggists don't have the appropriate system to interconnect with each other and know what prescriptions I may have been receiving at another drugstore, how can we rely, as we do now, on that professional advice? It's great advice we get. We get printed forms now that tell us about the drugs and what effects there are. What would happen to that professional advice if we were encouraged to go out and shop around?

Ms Peister: That's an excellent point, and it's a point we've been trying to make, the Ontario Pharmacists' Association and local associations across the province. We feel that by going to different pharmacies you get a fragmented patient profile, so if you were a diabetic or on heart medication, we may not know about that if you got that prescription filled at a different store. If you came in when you were out shopping and wanted a decongestant for a cold, if you took that drug and we didn't know you were on a heart medication, you could have an interaction between the two drugs that could put you in the hospital. We have always advocated that you deal with the same pharmacy so your patient profile is there, we know exactly what drugs you're allergic to.

My store is open on Saturdays and Sundays late in the evening. We have people coming in who went to an urgent-care clinic to get a prescription because their doctor wasn't available to see them. The doctor writes for a penicillin type of medication, and you have an allergy to penicillin. If you went to a different doctor and to a different pharmacy that wasn't familiar with you, there could be disastrous results.

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Mr Crozier: So the idea of shopping around—

Ms Peister: Is not a good one.

Mr Crozier: It's okay when it comes to tires but not so much when it comes to drugs. I'm serious. There could be serious consequences.

Mr Ibbotson: Would you shop around for a doctor?

Mr Crozier: Well, if Bill 26 goes through, we may have to.

Ms Peister: I think shopping around for your health is terrible.

Mr Crozier: Thank you. That's the point I wanted to make, that it's risky business.

The Chair: Thank you very much, folks. We appreciate your interest in our process and your presentation here today.

Mrs Caplan: I'd like to place a question on the record. There was inadequate time for me to question the excellent presentation from the region of Waterloo—and

no, it's not your fault. They've made some very serious suggestions of integrity on the part of the minister. In their presentation there's a letter dated July 5, 1993. The only thing that think happened between July 5, 1993, and July 5, 1995, was that the minister went from being the Health critic to the Health minister. The question I would put on the record and ask that the minister answer is why, given the letter he wrote on July 5, 1993, did he bring in the policies in Bill 26 that he vehemently argued against in his letter to the pharmacists on July 5, 1993?

My question to the minister is, doesn't he believe that the pharmacists' association, when he said, "Section 7 of the Ontario Drug Benefit Act provides the government and pharmacists with existing mechanisms that allow for fair and reasonable dispensing fees," had a reasonable expectation that this would be his policy in government? Doesn't he feel he owed them at least the courtesy of consulting with them before he brought in Bill 26, which dramatically changed what he led them to believe in July 1993?

I'd ask that he answer that as quickly as possible. I'm shocked by the presentation from the pharmacists' association and the evidence of duplicity that has been presented today. It's a question of integrity, and I'd like the minister to answer that very quickly. Obviously, something happened other than just the election. I'd like to know what information he had to suggest that he should not negotiate with the Ontario Pharmacists' Association and that section 7 was no longer valid. The PC Party told them nothing between 1993 and the 1995 election—told them nothing had changed. I would like to know what happened to change Jim Wilson's mind on how to deal with pharmacy issues.

SHEILA RICHARDSON

The Chair: Are the people from the Guelph-Wellington Coalition for Social Justice here? I understand that Sheila Richardson is here. Would you mind coming forward and doing your presentation at this time? You can get home for dinner earlier that way. Welcome to our committee.

Mrs Sheila Richardson: Good afternoon, fellow taxpayers. I am a registered nurse. Currently, I work full-time as a front-line staff nurse providing direct patient care in a small community hospital.

Recently, I had the privilege of representing thousands of staff nurses, having just completed a four-year term on the Ontario Nurses' Association board of directors. As the previous region 5 director, my representation included the regions of Halton, Peel, Dufferin and York. Therefore, I can speak with some authority and experience regarding health care reform and the proposed changes under Bill 26.

I am extremely pleased to be one of the fortunate few to have the opportunity to address this committee. I have come today as an advocate for patients, parents, nurses and the senior citizens of Ontario because I care very deeply about the health care system as a whole. Health care reform is an absolute necessity if we want to maintain a publicly funded system that upholds the historic, humanistic, Canadian principles of public

administration, portability, universality, affordability and comprehensiveness.

I will be focusing my submission on the following schedules set out in Bill 26: schedules F, G, J and Q.

Schedule F amends the Ministry of Health Act, the Public Hospitals Act and the Independent Health Facilities Act.

The establishment of the Health Services Restructuring Commission is a move in the right direction. I suggest that the jurisdiction of the Health Services Restructuring Commission be expanded to include community health and long-term-care facilities, not simply hospitals. For far too long governments have piecemealed the health care system and not provided mechanisms for proper coordination between institutional and community care. This has resulted in a great deal of frustration for consumers and providers, creating fragmented care that only helps to drive up the costs to the system. During this time of fiscal restraint, as hospitals deal with ever-shrinking budgets, patients are being discharged to the community more quickly, requiring a much higher level of care than previously. This process only shifts the cost from one sector to another. The long-term-care and community sectors are then left to absorb an increased patient load, yet, also dealing with decreased funds, they are cutting services too. In the end the patient suffers, with increased risk to the stability of their health as they slide through the many cracks and crevices with no resources available to stop their impending descent.

We need to fundamentally change the system and look towards a primary health care network model. This model would coordinate all sectors of health care, servicing a defined population or area. It will focus on health promotion and prevention, and consolidate health and social services. This challenge should be met by a salaried multidisciplinary team, which will provide the right service at the right time by the right provider for the right price to the right client. Salaried rather than fee-for-service providers will ensure that quality health care remains a priority. Current fee-for-service payments do nothing to address quality of care. It only encourages the provider to increase the number of clients seen per day. I'm sure we've all had to wait a spell in a doctor's office and then felt rushed through our appointment, often forgetting crucial information and questions we had.

Nurses can save the health care system money by providing some of the services currently being provided by physicians. Nurse practitioners need to be utilized to a greater extent. I encourage the government to address the necessary pieces of legislation to make this a reality.

The taxpayers of Ontario deserve to have their tax dollars spent wisely. Ensuring coordination of the system towards a seamless continuum of care will help to achieve this. It will decrease the readmission rates to hospitals due to a lack of care provision. An emergency room nurse recently told me, "I'm tired of becoming an expert at starting scalp vein intravenous on dehydrated, severely jaundiced infants." Mothers and infants are being discharged on average 24 to 48 hours after birth. The result is a rising readmission rate, especially of newborns. We need to ensure that there is enough time and staff to do the teaching required to help prevent these occur-

rences, with follow-through to the community. This is what preventive medicine is all about. It will save money in the long run. The commonsense saying "A stitch in time saves nine" certainly applies.

The role of district health councils in relation to the Health Services Restructuring Commission is unclear. The commission should work in conjunction with the district health councils, providing a link to local communities and permitting a vehicle for community input into decisions affecting local health care. District health councils have been studying and planning towards future health care for years, thus developing a priceless jewel of information and expertise that should not be ignored.

1530

To the best of my knowledge, the nursing community has yet to be officially consulted by this government in relation to the restructuring that is and will be occurring. I wonder why. Nurses form the largest group of health care providers in the system. The nursing perspective needs to be given the consideration it is due. After all, we're out there providing the direct care at all hours of the day and night.

We want to help create an efficient, cost-effective health care system. That is why I believe it is critical that the membership of the Health Services Restructuring Commission include representation from a prominent, front-line nurse. The proposed changes to the Public Hospitals Act require that physician-human resource plans be developed. I would go further to say that there are a lot more people providing care in hospitals than just doctors. If we are truly going to shift resources to the community, then we need to consider not only the money but the human factor as well. A comprehensive health-human resource plan needs to be developed that allows for redeployment to the community. We need to build on the human resources currently in our system so the knowledge, skill and experience will not be lost.

Throughout schedule F there are many recommendations that will help in restructuring efforts but many require expansion and a need to be more fully developed with appropriate regulation. There is, however, one aspect in the schedule that I find extremely disturbing. The extraordinary, unprecedented powers given to the Minister of Health with no appeal process whatsoever seem rather communistic to me. As far as I know, I'm still in Ontario, a supposedly democratic society. Not only does the Minister of Health obtain these broad, sweeping powers, but he does so without having to accept any of the responsibility for his actions. Time and again it is referred to that no actions against the government for acts under this bill will be permitted, creating instant immunity from liability. By doing this, the government has set itself above the law to which all persons are normally held accountable. I urge you to more clearly define the overriding powers of the Minister of Health and set guidelines that will ensure the input of advisory bodies in the decision-making process with an allowance for an appeal mechanism. One person should not hold such an enormous balance of power in the palm of their hand.

Schedule G, Amendments to the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the

Regulated Health Professions Act, 1991: The proposals under schedule G concern me greatly. Clearly this is nothing more than a new form of tax on the poor, sick and elderly. I predict the copayments will quickly become known as Harris fees and shall return to haunt this government by actually increasing costs to the health care system. By instituting a \$2 fee for each prescription filled under the Ontario drug benefit plan, you will be encouraging seniors to request the maximum 100-days dispensation of a drug. With medications taken routinely, this won't be a problem, but with new, untried prescriptions, this practice could result in substantially increased cost. The \$6.11 dispensing fee per prescription and the \$100 deductible per year per person may not be able to be absorbed by some seniors, even with an income over \$16,000.

I guess the more medications you require, the sicker you potentially are and the more you're going to have to pay. End result: seniors trying to defray their own costs, becoming their own pharmacist and physician, filling only certain prescriptions. The direct consequence will be a dramatic increase in hospital emergency room visits and admissions and a resultant escalating placement of the elderly in long-term care facilities. The potential number of heart attacks and stroke victims should horrify us all.

These amendments are not going to stop doctors from reaching for the every-ready prescription pad, nor will it change the mindset that a pill is the answer to everything. The government needs to address the real issue here, which is a very clear need for a proper drug utilization program. Education is the key.

These proposals will most certainly have a negative impact on the health of the poor and elderly, driving up the costs of our system in totality. I urge the government to very seriously rethink these proposals for the betterment of all Ontarians.

Schedule G: amendments to the Pay Equity Act. The Ontario Nurses' Association has a long-standing history as an advocate for pay equity. We represent 50,000 nurses in a 98% female-dominated profession. The government is proposing the elimination of the proxy method for achieving pay equity effective January 1, 1997. The proxy method was developed to assist women working in employment settings that had no comparable male job classification. An adjustment of 3% of an employer's 1993 payroll will be all that the women trapped in the proxy methodology will receive as pay equity compensation.

As a fellow nurse, I feel compelled to speak against these amendments. I know of nurses personally working in the nursing home sector and for the VON who will be affected by these changes. Under these proposals, they will never have an opportunity to achieve full pay equity. This is unjust and, simply put, unfair.

What the government will be doing is rewarding employers who have procrastinated in their pay equity obligations. These employers utilized stalling tactics to the very outer limits of reasonable, wasting an exorbitant amount of time, energy and money that could have been put to better use. For our members directly involved, it adds injury to insult that this type of irresponsibility can reach such a deplorable conclusion.

This government should uphold the principles of pay equity that you are on record as supporting when the original bill was tabled in 1987.

Furthermore, I support ONA's suggestion of allowing proxy payments to be phased in at 1% of an employer's payroll for a period of eight years. This is the current method afforded under the proportional and job-to-job value scenarios. To not extend the same opportunity to the nurses caught in the proxy method is to heap discrimination on top of discrimination.

I respectfully encourage the government to reconsider their proposal and seriously consider ONA's fiscally responsible alternative suggestion.

Schedule Q, Amendments to Various Statutes with Regard to Interest Arbitration: The amendments regarding interest arbitrations will require arbitrators to consider an employer's ability to pay in settling wage awards. This sounds fairly reasonable when it's viewed narrowly. However, my experience tells me that it will only increase the delays and costs of our already overburdened arbitration system. The employer will argue ability to pay and the union will counterargue, and so on and so on and so on. The number of appeals, along with costs, will skyrocket, and the only ones laughing will be the lawyers, all the way to the bank with our tax dollars. It also gives an economic incentive to employers to mismanage funds, something for which employees should not have to suffer.

Schedule Q needs to be removed from Bill 26. We need to improve the collective bargaining and arbitration process. Central bargaining is a cost-effective method and should be strengthened. The government needs to sit down with employers and unions to find workable solutions to the arbitration process.

In conclusion, I would like to encourage the government to provide for increased consultation and evaluation of submissions regarding Bill 26. This is a massive piece of legislation that needs to be broken up into sizeable chunks so it can be dealt with appropriately.

Change to our health care system needs to occur. We do have too many hospitals and inefficiencies that currently exist. Coordination between hospitals, community and long-term care must be facilitated to create a seamless system that truly meets the needs of everyone. The time to start this process is now. Working together, we can do it. We possess much of the information needed to forge ahead and create a shared vision of health care as it ought to be.

Our health care system is too precious to lose. Having worked in Texas in the early part of my career, I know this to be true. I really value our system. The overcare for those who had money and the undercare for those who didn't left a great impression on me. I remember one specific 49-year-old patient who had a cardiac arrest, and the subsequent argument that took place outside her room between a resident and intern after she had been resuscitated. You see, she didn't have any health insurance. Consequently, money won the argument and she was placed on a step-down cardiac unit rather than the intensive care where she would have gone had she been insured. She died two days later, and I'll never know if

her placement made that defining difference between life and death. I'll never know, but I rather think it did.

The decisions we make today regarding health care will determine whether we preserve a publicly funded system for tomorrow. The business community should take heed. Our health care system provides us with a rare competitive advantage. We spend 10% of our gross national product on it compared with the 14% that the States spend on theirs. Four per cent of billions of dollars is a lot of money.

There exists a terrible danger that the very speed of health care reform and the lack of appropriate consultation and professional input may not give us time for common sense. Slashing and burning without a comprehensive plan for our future could cost us all dearly in money, decreased health status and our very lives.

Nurses are the glue that holds the health care system together. Twenty-four hours a day we are on the front lines assessing, planning, providing and evaluating patient care. I cannot emphasize enough the importance of a nursing perspective in decisions about health care reform. Nurses, since the time of Florence Nightingale, have put patients and their best interests first. We will continue to do so. For all the knowledge, skill, expertise and dedication that nurses possess, we have frequently and repeatedly been ignored by government. This is one of the major reasons health care is in the state it is.

ONA and the nurses of Ontario are ready to assist you. Involve us now so Ontario will not lose the opportunity to make substantive, constructive changes that will enhance and preserve our health care system for future generations.

Thank you for allowing me this time and your attention regarding these very critical issues.

1540

Mrs Ecker: Thank you very much for coming, and please don't feel you need to apologize for feeling very strongly about this issue. If there's one issue that unites all of us from all three parties, it is a concern for the system. While we may differ in some ways about how we maintain the system, most of us in this country very much care about it.

One of the interesting comments in the document you handed out to us today is:

"Health care myth: Ontario's health care system is underfunded.

"Not at all. Ontario has the most expensive publicly funded system in the world.... Of each dollar in Ontario's health care budget, 44 cents goes to hospitals...27 cents goes to OHIP.... But people here do not live as long as those in Japan or Australia, both of which have less expensive systems. The problem is not money—it is the fact that money is poorly allocated and inefficiently used. We can't buy our way to better health, but we can think and spend smarter."

That probably sums up very quickly what governments have wrestled with to try and reallocate resources within the system.

One of the suggestions you make, which has come up throughout the hearings and which I find quite interesting, is that the hospital restructuring commission, you quite rightly point out, should be linked to the district

health council local planning. That should be very clearly there, and the district health councils do remain in the legislation, and their role as written in the legislation does not change.

One of the interesting points you make is that the role should be broadened, that the commission's terms of reference should include something to do with community services. Do you want to elaborate on that? I find that a very interesting concept.

Mrs Richardson: If we're going to shift the resources to the community, we can't just deal with the hospitals. That's what we've done historically. Everyone stayed in their own little silos, the hospitals over here, community health there, and meanwhile you've got administrative functions being duplicated everywhere and costing us a fortune. We need to reallocate the dollars, and you need to have the commission broadened so it can deal with all aspects of health care and not just the hospitals. Staying in one silo is not going to break down the walls and allow us to create the health care system we need to create, which should be comprehensive and should allow for patients moving from the hospital quickly into the community.

Mrs Ecker: One of the other points you made is doctors reaching for prescription pads. We have heard some concern from seniors about what they've seen as overprescribing of seniors. With your experience in the system, dealing with physicians on a daily basis, do you have any advice for what would be the best way to encourage physicians to use drug utilization guidelines or prescribing guidelines or whatever the term might be?

Mrs Richardson: What we're probably looking at is the fee-for-service system. That needs to be scrapped. Fee-for-service does nothing for quality of health care. As I said in my presentation, the doctors, through no fault of their own—they want to make a good salary so they book and overbook and overbook. They're seeing patients and turning them in and cranking them out just as fast as they can see them.

It's the same thing in the hospitals with the patient-weighted case costs. All that tells the hospitals to do is move the meat faster. That's what they've been doing, and you end up with people out on the street with no community resources set up to look after them, and then they're readmitted back into the hospital.

As for how you get through to the doctors, you need to put them on salary and then they will have the time and devote the time. You also need to utilize nurse practitioners. Nurse practitioners have been in the system for a long time. They've been working up north where no doctors are willing to work and they've been coping with a lot of the skills that the doctors utilize down here.

Nurses are trained not just to treat the sick mode. We're trained to look at preventive medicine, and preventive medicine is what we need to develop more. Nurses are probably very well trained to do that.

Mrs Caplan: Thank you for an excellent brief. I'm going to start by agreeing with you that the commission in Bill 26 is in fact for hospital restructuring and has to do with hospitals only. It is not a health systems approach, nor is it an approach that will see to the proper shift and see that those aspects are in place, necessarily,

because we don't know how it's going to work, what the mandate is. It's unclear. We have not had any of that policy discussion before us, because this isn't a health bill; it's a money bill.

One of the things we're trying to put in place—because notwithstanding what Mrs Ecker was just saying, there's no guarantee of any process. While the district health councils, it is true, remain advisory to the minister, there's nothing in this legislation that requires a report from the district health council and, frankly, nothing in this legislation that requires a transitional plan or a labour adjustment plan or any of those policies to be put in place. I'm very concerned, because nurses should have been consulted, as should the doctors and other important stakeholders that this government sees as vested interests. It's an insult to have left you out of any consultation.

Do you think that before the commission is able to implement the restructuring, there should be a human resources plan in place, with transitional policies that will give some comfort to the staff, nurses and other hospital workers, doctors who may lose their privileges? Don't you think the minister should have to approve that kind of plan before the commission is permitted or has any authority to implement a restructuring?

Mrs Richardson: You make a very good point. How do you know where you're going to go if you don't have the plan behind you?

Mrs Caplan: This doesn't require a plan.

Mrs Richardson: Our real concern is that, as you say, district health councils are completely left out of section 8, where they were before; they are not mentioned. In fact, I met with an MPP in the riding where I work and he more or less implied that district health councils could potentially be a thing of the past. I'm extremely concerned. You're going to lose all this expertise that has taken years to develop. And I would go further to say that district health councils need to be mandated to have front line providers on them. We see some that do, but some district health councils tend to be very administrative- and provider-heavy.

Ms Lankin: To follow up, there is a requirement on the composition, but some of the problem is in the definition of "front-line," the way nurses see it and the way some other health professionals might be viewed to be front-line. I understand the problem that gives rise to in DHC makeup in some communities.

Sheila, I'm really pleased you got a chance to present. I realize that you're here on your own and not officially representing ONA, but I'm glad you're here. ONA hasn't been able to get on. They had one spot very early in the first week and had to give it up because they didn't have time to finish their analysis of the bill, and they haven't been able to get on anywhere else. We've only had one other nursing presentation from Vickie Kaminski from RNAO. We've been through almost three weeks of hearings now and you're the second nursing presentation. The whole profession really has not been heard from, and there are other health professions and health practitioners very much affected by this bill who also haven't had a chance. So I'm glad you're here.

I've got two questions. One's quite technical and quick. You referred to nurse practitioners and the change

in legislation required to allow them to come into practice. I maybe have forgotten, but I thought that under the Regulated Health Professions Act, when we fiddled around at the very end with the scope of practice for nursing, we left room for that to grow under the college with college input, so it wouldn't require a legislative change to bring back nurse practitioner. Am I wrong?

Mrs Richardson: Actually, having just finished on the board in December, we had a discussion regarding this and certainly the college is looking towards developing and implementing that. However, pieces of legislation do need to be opened. One is the pharmacies act because of the dispensing situation. The other is the laboratory act in regards to withdrawing blood.

Ms Lankin: As long as you're not telling me that we have to open the Regulated Health Professions Act again.

Mrs Richardson: Unfortunately, different acts that do have to be opened—

Ms Lankin: The ministry staff over there are all laughing, and you know why. They went through three governments and eight ministers of Health trying to get that piece of legislation done.

My other question is about your experience in the United States. I'm also looking at this publication—which I remember getting when I was Minister of Health but haven't seen for a while—about the Oregon model. We've heard people make reference to a list of core services and the Premier talk about things we do now that aren't medically necessary. I read into the record a letter to the Minister of Economic Development, Trade and Tourism about a conversation he had with a doctor where he talked about a core list of services.

In Oregon where they did this priority listing—it involved a public process, so that part of it was good, but they excluded about 15% of the services because they couldn't pay for it. It was bottom-line fiscal. These exclusions included things like the common cold, treatment for obesity, aggressive treatments for terminal cancer, AIDS and premature infants. Can you comment on what that move to core services, particularly under this bill where there's no public process left, might mean here in Ontario?

Mrs Richardson: That will mean increased health costs because when people don't get the services they need or are afraid they're going to end up having to pay for, they will not go to see a physician and will end up in emergency rooms in a much sicker condition than they would have been originally.

The Chair: Thank you, Mrs Richardson. We appreciate your interest in our process. Is the Guelph-Wellington Coalition for Justice here yet? We're going to recess for five minutes till we see if our next presenter arrives.

The committee recessed from 1552 to 1556.

ONTARIO HEALTH RECORD ASSOCIATION

The Chair: The Ontario Health Records Association, represented by Marci MacDonald and Gloria Ringwood, are here nice and early and have agreed to go ahead. Please come forward, and you also will get home for dinner earlier.

Ms Gloria Ringwood: Thank you very much. I'll briefly give a background on the Ontario Health Records

Association. We were established in 1935 to represent and advocate for health record professionals in the province. We represent some 800 members employed in a variety of health care settings: hospitals, community health care and so forth. The association's focus is on health information management, which includes the management of patient records. That will be our focus today.

In response to Bill 26, our association has looked at four of the schedules outlined, schedules F, G, H and K. We've listed points that are themes through these four schedules that we would like to express our concern about.

(1) The schedules refer to:

—The collection of patient information. The concern is with who will be collecting the information.

—The disclosure of patient information. Again the concern is with who will be disclosing the information collected and to whom it will be disclosed.

—Destruction and/or storage of patient information. The concern is with who will provide the storage and the collection of this information, under what conditions, and how or when the collected information will be destroyed.

(2) The specificity of requested information contained within the patient's record is not identified. Will the requested information be identified with the patient's name, date of birth, address, medical history etc, or will the information be aggregated in such a way as to maintain the anonymity of the patient?

(3) How will individuals designated to inspect and/or obtain patient information on behalf of the minister or general manager be selected? What specific professional and/or other qualifications will be employed? How will privacy and confidentiality of the information be maintained with these individuals?

(4) The Minister of Health and general manager may disclose patient information. Again, what information, to whom, and under what circumstances? Will the patient be notified? Will patient consent be obtained? Is the patient's right to privacy and confidentiality being respected?

(5) Bill 26 addresses the need to access patient information, to review the information and to disclose the information regardless of the patient's right to privacy where their personal information is involved. How will this concern be addressed?

Due to this issue, there is the potential for health care providers to avoid the comprehensive documentation that currently occurs with patient medical history. Conversely, the patient may be reluctant to disclose the full nature of their health condition for fear of disclosure of this information to a third party.

(6) Currently, OHIP completes random audits of physician billing by sending to a patient a form. This form indicates the procedure and/or treatment provided, asks the patient to complete the form, provide their consent to disclose the information, and this completed form is then forwarded to OHIP.

The key points are: Is the patient aware that their personal health care information is being accessed? They are providing their consent in that case. Under the provision of Bill 26, how will the patient be apprised that

their personal information is to be accessed and how will the patient's consent be obtained?

(7) Another issue we looked at was the terminology of "frivolous and vexatious" request for information. We wondered how this was going to be qualified.

(8) In the event of hospital closure within the hospital services restructuring, who will retain ownership of the health record? How will the patient information maintained electronically or on paper be retained for subsequent access? How will the privacy, confidentiality and security be addressed?

(9) There is also reference in the bill to the establishment of agreements for the collection, use and/or disclosure of personal information, that is, indirect collection of information for the minister. What individuals, businesses and/or agencies will be solicited? What qualifications will be required? How will patient privacy and confidentiality be maintained?

In summation, the Ontario Health Records Association has concerns, after reviewing Bill 26, in regard to the patient's right to privacy and confidentiality of their personal information, how access to personal information will occur and by whom, how and to whom personal information will be disclosed and how this personal information will be retained/stored or destroyed.

Furthermore, our concern is heightened not only with the issues pertaining to how information will be collected, disclosed, destroyed and/or stored, as outlined in the bill, but with the methods of electronic information transmittal, which are not addressed. Thank you.

Mr Crozier: Thank you for your presentation. You've raised some interesting questions. These folks here have attended many more of these sessions than I have, but you've raised some questions I haven't heard before except in the general area of privacy. I'd like your comments on a couple of things.

I asked a physician, if this bill were passed in its present form and those areas relating to privacy were left the way they are, might it lead to less information being on a patient's file because there may be a reluctance of physicians to record that information? I assume that's something you may have been concerned about.

You've raised these questions and you deserve answers, because you're professionals in your field. I suggest that what's going to happen is that the part that remains unseen yet, which we haven't discussed or been able to discuss, which is not in these 211 pages, are regulations. Regulations are written by the ministry and are put into effect without any debate in the Legislature. It may be that a number of the questions that you raised will be answered through regulation, but will they be answered satisfactorily and will you have an opportunity to have input on them? I think those are two additional questions.

I might say too, and you might be able to comment on this because of your involvement in the records profession, that part of what we seem to be after in this bill is to go after fraud. The only thing is, it appears to me, that it's fraud on behalf of health care givers where, I suggest, it's relatively limited.

What hasn't been addressed, or at least what I haven't come across yet and someone may want to comment on,

is if we really want to get after fraud, I guess we want to get after abuse of the system where citizens of other countries may be coming to Ontario and accessing our health care system when they shouldn't be. That leads to what kind of cards we're going to use to access the system.

I hope you've been able to keep track of those three or four things that I mentioned and maybe give some comment on them.

Ms Ringwood: In regard to physician reluctance to document fully in the chart, I would think that would be a real concern. In contact with members of medical staff in various scenarios, that issue with them has been expressed and they will pursue, I think, a path of not fully documenting. They may keep their own private notes, but it's not going to appear on the chart. That causes concern when you're trying to deal with treatment of a patient across many different types of health care and you want to ensure that you have as much comprehensive medical history of a patient as possible. That is one reason why I raise that in the document. We do have concern with that.

Ms Marci MacDonald: Patients themselves may not feel comfortable disclosing it even to the physician.

Mr Crozier: Exactly. Under these circumstances.

Ms MacDonald: Yes. Very reluctant.

Mr Crozier: I raised more questions, I guess, in addition to yours really, and the only remaining one I have is, very quickly: Since you're an association, do you regularly have consultation by your association with the government?

Ms Ringwood: Not with the government. Indirectly. We have association with the Ontario Hospital Association directly. We do work with the joint policy and planning committee on certain issues, and minute times with the ministry themselves in terms of issues. But this issue is very near and dear to our hearts in terms of what our profession is all about, and very much so that we are concerned with the privacy, confidentiality and security aspects related to the bill.

Ms Lankin: In light of that, and I think I know the answer to this, given that you're the only professional association whose sole purpose is dealing with professionals who deal with health information, were you consulted with respect to the drafting of Bill 26?

Ms Ringwood: No.

Ms MacDonald: Absolutely not.

Ms Lankin: I thought I knew the answer to that.

Ms MacDonald: We're hoping that now you know we exist, you might do so in the future.

Ms Lankin: I actually was aware that you existed through the JPPC and the work that was being done on HMRI and everything. I knew that you were a party to that.

Ms Ringwood: It's just that when we get to the consultation processes around issues like this, it tends to be that associations such as ours are lost in the group of other professions that are out there, and we would very much like to be involved in any other consultative processes that do occur.

Ms Lankin: The government has said that it's certainly not their intent to disclose private health information

willy-nilly, and I think we can believe them on that front. But the concerns are in the way in which the bill's been drafted and the open-ended powers, and even inadvertently what that means when there aren't really tight rules around who gets to see it. When you expand it to all the people who can have access it creates problems.

For the first period of time during the hearings, the government said that really this was about being able to go after fraud, and you would have to say primarily physician fraud, although Mrs Ecker refers to 7,000 patients who sought assistance from five family physicians or more in a given period of time. The way in which patient records and billings and those sorts of things are done, you can't cross-reference what one person does with their health card, where they go, but you can cross-reference what one doctor has sent in in terms of billing. So it would only get at physician fraud and, quite frankly, it's the billing information and financial accounting you need, not the personal health information. So that sort of gets dismissed.

1610

Just recently they brought up this issue of the Institute for Clinical Evaluative Sciences needing this information to do epidemiological. Again, you don't need individual, you need HMRI data, which is being provided to David Naylor and ICES—

Ms Ringwood: That's right. As long as it's aggregated data. The patient identifier is not an issue.

Ms Lankin: Let me tell you what I believe that provision is for, to be able to do anything else you want with and disclose at any given time. It is to contract out OHIP and the health card.

The minister, when he was the critic, was very concerned about health care fraud, Americans using our health care etc, and a new health card is being introduced. In the previous government's time they did a pilot project of smart card technology. They determined that the issue of the electronic transmittal of data was very, very complicated with respect to privacy considerations and that if we move in that direction, which has a lot of value, should be phased in and there's a five-year renewal on that new health card and smart card technology can be phased in as we get the privacy problems all worked out.

The new minister, to make his splash, wanting to go to smart cards, has put the other health card on hold and has said he's going to go to smart cards. He can't do it inside, he's going to contract that out, and all that information needs a provision to be able to disclose it to the company that's going to provide it. There are lots of issues around electronic transmittal which have not been worked through. Can you comment on that, because I believe that's the real purpose behind these provisions.

Ms Ringwood: The Ontario Health Record Association recently, because we recognize that there is definitely a weakness in that area within the province, has a variety of community information networks that are being established and were through the Ministry of Economic Development, Trade and Tourism. Their intent is to build central repositories where patient information is stored and therefore accessed within the community by several individuals.

What we see as an issue is what patient information is going to be housed in these repositories and who is going to access it. There have been indications where pharmaceutical companies at times have made indication that this would be information that they would like to have access to for their own purposes, research and so forth. In light of that, our association has formed a steering committee and what we've tried to do is bring together as many stakeholders as we can.

We do have some representation from the Ministry of Health in the sense of their information systems branch. We have OHA, we have OHMISA, which is the Ontario Hospital Management Information Systems Association in the province, ourselves. We have had contact with the Ontario Medical Association, which is willing to participate, also the privacy commissioner's office.

The intent of that group was to establish one committee that would be able to start to address the issues in terms of standards as they arise, recognizing that we're all independent associations, some volunteer, some not. The ability to do this on a more global perspective may be limited, but it is something our association would like to see brought to the forefront, possibly with some backing from the ministry, because I definitely see that we need to address the transmittal of electronic patient information.

Ms Lankin: I wish you well in that work. What the privacy commissioner would argue, and I suspect he would argue this because he argued it with me when I was minister, is that we've got to get on top of these issues before we move to smart card technology. In fact we should probably have health information privacy legislation, specific legislation unto itself. I think what the minister's trying to accomplish is too open-ended here and we need the rules written in legislation.

Ms Ringwood: That's exactly what we're trying to point out, that it's too loose and we need to have a specific regulation.

Mr Wettlaufer: Thank you for your presentation. Could you tell us how many people today and who they are who would have access to a patient's records?

Ms Ringwood: If you're in a health/hospital institution it would be anyone providing health care to that patient, depending on their need-to-know basis. It could be a patient's insurance company. It could be their family physician. It could be from a legal perspective, that there is either a claim against the Facility or they're pursuing their own claim when they've been in a motor vehicle accident, and therefore you're working with their legal counsel. Myriad individuals would be able to have access.

There are safeguards in place, and that's what our profession works towards. We are employed in the facilities to provide a secure environment for the information and to maintain privacy and confidentiality of those records by ensuring that work is done with the corporations and that the necessary policies are in place to support that.

Ms MacDonald: One thing I'd like to add is that in all the scenarios Gloria pointed out, there are all kinds of cases where they've given written authorized consent for that disclosure.

Mr Wettlaufer: Nevertheless, a fair number of people would have access to those records.

Ms Ringwood: But with patient consent.

Mrs Ecker: What about access under some of the regulatory colleges' investigations, the Medical Review Committee, some of the quality assurance provisions in a hospital? Are there specific patient consents for that information?

Ms Ringwood: We're looking at quality assurance information. The intent behind that information is to assess the quality, the care within the institution, to provide the most appropriate care. They are looking at aggregate data. They're not specifically looking, I would say in 90% of the cases, at the patient; they're looking at the procedure, the treatment, the care provided, the outcome.

Mrs Ecker: That's right, but they do need access to the patient record to do that, as you point out, very useful, worthwhile—

Ms MacDonald: Or more often it's compiled by folks like ourselves, and then the aggregate totals and the final stats are presented to the committee. Very rarely will they sit down and look through 100 patient records.

Mr Wettlaufer: This is the medical review committee that does this.

Ms Ringwood: It also could be the corporate quality assurance program.

Mrs Ecker: The medical review committee, as I understand it, basically, if there is a question of billing or something, would take literally hundreds of records from that physician to look into them, and I didn't know if there was an actual request to those patients to say, "We are going to take your file." They sometimes go to patients and ask them but the actual review overall didn't necessarily ask for permission from a patient to include that file in the medical review process.

Ms Ringwood: In certain circumstances, there will be consent; not in all. Recognizing that these individuals looking at the charts are health professionals providing care, and they do practise—

Mrs Ecker: Public members are on the medical review committee. I'm not trying to—

Ms Ringwood: I'm just looking corporately. I'm trying to think of a public member in the corporation where I work, and we don't have one.

Mrs Ecker: There are public members on the medical review committee who are there to balance it out.

Ms Ringwood: But they're looking at aggregate data; they are not looking at the charts.

Mrs Ecker: In some cases, the charts are part of that process, as I understood it.

Ms MacDonald: I understood patient information, such as name and address and date of birth, would've been removed.

Mrs Ecker: They are trying to do that now. They didn't originally.

Your points about confidentiality are quite valid, and confidentiality of records is a principle we all respect and all want to maintain. The interesting point is that very few people have any idea what the current access is to health records and that, as Ms Lankin has pointed out, the commissioner has been lobbying many governments to have actual health confidentiality legislation, which might indeed in the long run be quite helpful.

Ms Ringwood: It would very much be helpful.

The Chair: Thank you very much. We appreciate your presentation today and your interest.

Has the Guelph-Wellington Coalition for Social Justice arrived? I guess they're not going to show up. The only other group to hear from is the Ontario Health Coalition. They will not be ready until 4:30, so we will recess for 10 minutes.

The committee recessed from 1618 to 1630.

ONTARIO HEALTH COALITION

The Chair: Our last presenter for the day has arrived. The Ontario Health Coalition, represented by Dan Benedict, co-chair, Julie Davis, co-chair, and Adrianna Tetley.

Ms Julie Davis: We're here today to make a presentation on behalf of the Ontario Health Coalition. Our coalition is a coalition of seniors, anti-poverty groups, women's groups, nurses, doctors, Indian friendship centres, coalitions for social justice, and labour. We have members throughout Ontario, from the far north to the south, from cities to towns and throughout rural Ontario.

The Ontario Health Coalition is committed to maintaining and enhancing our publicly funded, publicly administered health care system, and we believe that the principles of the Canada Health Act must be honoured and strengthened. The Ontario Health Coalition endorses the 10 goals for improving health care put forward by the Canadian Health Coalition, and we believe that all members of the community should have the right to food, security, adequate housing, quality child care, employment, education, health care and a safe environment in our homes and our communities. We will promote social and economic justice to build a society where every participant contributes fairly.

We believe Bill 26 totally violates our vision statement, and we call on the government of Ontario to immediately withdraw Bill 26 in its entirety. Any consideration of the elements of Bill 26, in our view, should be retabled and discussed in manageable pieces, and the public should have the opportunity for democratic discussion, debate and full consultation.

For any changes which affect our health care system, we would argue that the government must establish a consultation process that involves users and providers of the health care system, advocates for health care, for health care workers, labour and members of the medical profession. The 10 goals for improving health care for Canadians, which is part of the appendix, must provide the basis for any review of the health system in Ontario.

We welcome the opportunity to make our concerns clear to you today, although we are appalled that it took such drastic action inside and outside the Legislature before this government succumbed to even this limited consultation process. We protest against the obstacles to a far broader consultation and we hold the government responsible for driving the citizens of Ontario to hold unofficial parallel hearings in order to voice their concerns, as took place in Sudbury earlier this week.

Our concerns with the omnibus bill are overwhelming. We want to start by addressing some of our concerns

with what we believe are the ideological underpinnings of this bill.

First of all, we do not believe that Bill 26 is about the debt and deficit, or about getting spending under control. According to Stats Canada, Ontario's social program spending per capita is about 9% below the national average for all provinces and the overall provincial taxes per person in Ontario in 1993 were 4.4% lower than the national average. We also know that health care spending in this province is not out of control. It has not increased in the last four years, and this reason definitely does not justify taking over the most minute aspects of our health care system, shutting hospitals or introducing user fees.

Bill 26 is also not about reforming the health system for the benefit of Ontario and it is not about ensuring that we have a health care system in the 21st century. To our minds, Bill 26 is about three things: finding dollars to pay for the income tax cut for the rich, privatizing our health care system and putting unprecedented arbitrary power in the hands of the ministers of this government.

It is about taking our publicly managed health care system and turning it over to the private corporations without regulations or controls. It is about handing our health care system to the private sector to make profits on the backs of the poor, the middle class and the vulnerable. It is about two big corporate winners: private health care firms and multinational drug firms.

It is about government turning its back and its responsibility for being the guardian of our social programs. It's about entrenching an environment of survival of the fittest, where anyone in need is seen as a blight on society.

It permits, and we would argue that it even encourages, extra billing and entrenches two-tier medicine: one tier for the rich and one tier for the poor. We believe that it clearly violates the Canada Health Act.

We also believe that it's an assault on democracy, in that it takes all power away from local hospitals, local communities and the medical profession and places it all in the hands of the ministers and cabinet.

The ministers and cabinet or anyone they appoint are not held liable for any decisions or actions they may cause, and the bill states they have power over the courts and no one—not citizens, not the workers, not the doctors, not the hospitals—has any right of appeal. We believe this to be an arrogant show of power and self-righteousness when the cabinet and the ministers feel that they and they alone have the right and the knowledge to make decisions affecting the health of citizens in Ontario.

Throughout Harris's mandate, he constantly tells the public and the poor to break their dependence on our social security programs, yet in Bill 26 he shelters his ministers and his appointees from any responsibility for themselves or the situations they might create.

No sector is as significantly affected by Bill 26 as the health sector, and we have serious concerns with several aspects of the schedules that affect health.

Schedule F is a direct attack on the principles of the Canada Health Act. It gives the ministers and their delegates the arbitrary power to close public hospitals and the equally arbitrary power to invite private American or other profit-making corporations to open licensed fee-

charging facilities in Ontario. It permits a wide use of user fees and extra billing practices and firmly establishes two-tier medicine.

The Ontario Health Coalition cannot support any move in these directions, and we call on the government of Ontario to withdraw schedule F, the schedule that amends the Ministry of Health Act, the Public Hospitals Act, the Private Hospitals Act and the Independent Health Facilities Act.

Specifically, we oppose the following amendments to the Ministry of Health Act: the establishment of a Hospital Services Restructuring Commission with a mandate to implement the government's agenda on hospital restructuring, without any accountability to the community and with total protection from any liability for the negative consequences of its implementation of hospital restructuring; and the deletion from the Ministry of Health Act, section 8, of any references to district health councils.

In the bill there are no restrictions on the duties of this hospital restructuring commission. The minister can delegate any authority he wishes to this commission, which will be empowered to carry out restructuring in whichever way they deem appropriate. There is no requirement to consult with the community.

The government can order it to run roughshod through communities, close or merge hospitals, all in the next four years. The government can then blame the commission for any community outcries because, as stated in a recent press release, "The powers will be given to the commission, not the Minister of Health, to restructure hospitals." On top of this, both the government and the commission are protected from any liability or damages.

In the proposed amendments to the Public Hospitals Act and the Private Hospitals Act our coalition opposes:

—The virtually unlimited power given to the Minister of Health to dictate every detail of the hospitals, including the funding, operation, closure and amalgamation of public hospitals.

—The fundamental changes to the democratic community governance structure of community boards of directors of hospitals and the overriding power of the Minister of Health over all decisions of the community board of directors without their input.

—The power of the minister to close or amalgamate hospitals on fiscal and budgetary reasons alone, without regard to the quality of care.

—The definition of "public interest." The minister can determine that the only public interest issue is the availability of resources. The availability of resources is a matter of priority. The Minister of Health may well find less resources available for health care because more is needed to cut the income taxes of the well-to-do.

1640

We also oppose the power to direct hospital supervisors to implement the minister's decision and to take over the powers of the local board of directors; the protection of the minister, investigator, hospital supervisors and board of directors from any liability as a result of hospital restructuring; the power of the minister to close or terminate any grant of any private hospitals without notice; and the fact that all hearings or rights of appeal have been repealed.

Why is Ontario in such a hurry to close and merge hospitals? For those of you who may think we have too many hospitals with too many empty beds, maybe we should stop and ask the question why the beds are empty in the first place. At times it was because the funding had been cut over the years and the hospitals had no choice but to leave those beds empty; at times it was because people had been sent home before they were physically ready to go and before arrangements could be made for the necessary community services, if they existed at all; and at times it was because people had been refused admission.

Ontario already has the lowest length of stay for patients in hospitals and the fewest number of hospital beds for every 1,000 people in Canada. The pressure is continually to get these numbers down, to reduce the length of stay in hospitals and to reduce the number of beds, yet no one is asking the very important question: What about the quality of care? What should be the standard to provide good quality of care for the residents of Ontario as we enter the 21st century? Bill 26 does not respond to this vital and pertinent question. Instead, it is cost, not quality of care, that is determining our standards. Bill 26 gives the arbitrary power to the minister and to the hospital restructuring commission to close and merge hospitals based on cost alone.

In 1994, the Provincial Auditor stated that the Minister of Health does not have a system in place to monitor bed closures to ensure that service levels are maintained as beds are reduced and that service reductions are not offset by increased waiting periods for treatment. He went on to state that the Ministry of Health does not collect waiting list data, with the exception of cardiovascular surgery and cancer radiation. Also, no one is monitoring the readmission rates of people who have been discharged too quickly and then readmitted sicker than before.

Finally, there is also no statement in the bill that states that any potential savings from the hospital restructuring would be reinvested in the community to cover gaps in service. There is no attempt to move or retrain workers. There is no commitment to ensure that capital dollars are in place to modernize the remaining facilities to today's standards.

Under the proposed amendments to the Independent Health Facilities Act, we oppose:

—The power of the minister to unilaterally create independent health facilities by regulation alone.

The power of the independent facilities to charge a facility fee over and above what they receive from the government for insured services. This is called extra billing.

—The deletion of all preference for non-profit or Canadian, thus opening the doors to private American or profit-making corporations to open licensed, fee-charging facilities in Ontario.

—The removal of the requirement for public tenders, that allows the minister to handpick the corporations or organizations to deliver the service, thus creating an open invitation to favouritism and/or corruption.

—The deletion of the definitions of "health care" and "health record" and the changing of "insured service" to just "service." This allows for deinsuring services and implementing user fees in other parts of Bill 26.

—The powers of the minister to deduct from physician payments any amount that in the minister's opinion should not have been paid, with no right of appeal for the physician. This means that if a doctor provides a service that later the government decides was unnecessary, the doctor will not get paid for providing that service. This process could lead to doctors hesitating to send people for assessments.

Schedule F proposes changes to the Independent Health Facilities Act that will challenge our ability to maintain a universal, accessible, not-for-profit publicly administered health care system in Ontario. It provides the framework for the further entrenchment of the two-tiered health care system, one for the rich and one for the poor. It specifically accelerates the privatization and incorporation of our health care system, and the deletion of the tendering process allows the Minister of Health to handpick corporations or individuals who will be able to open up businesses and franchises of health care clinics that charge people money.

In tandem with the massive cuts to hospital services, the new legislation allows the health care gaps to be filled by more private clinics or organizations intent on making profit from the sick or the elderly. It's a potential gold mine for the American corporations who are extremely interested in our health care system. That corporate world calls Ontario, and I quote, "the world's largest unopened oyster," and they refer to care for the elderly as "mining grey gold." There are alternatives to privatization, and government must work with users, the providers and the unions to review and implement alternatives without privatization and without user fees.

Mr Dan Benedict: I'm Dan Benedict. I'm co-chair, along with Julie, of the Ontario Health Coalition. I'm also the co-chair of the Ontario Coalition of Senior Citizens' Organizations.

We call for the withdrawal of schedule H, which amends the Health Insurance Act and the Health Care Accessibility Act. We oppose the removal of all references to "medically necessary" services. This opens the door to serious delisting of services. We also oppose the power of government to unilaterally determine whether medically necessary services are insured services or not.

We oppose the power of cabinet to determine the types of services provided to persons in prescribed age groups and the power of the general manager of OHIP to determine whether services were medically or therapeutically necessary. Some of you may have visited lands in different parts of the world where ancient people are sent up on mountain tops to disappear from circulation, and you might find that as useful in solving the problem of older people who get sick as the government's intentions here.

We're also opposed to the power of cabinet to unilaterally establish the "basic fee" payable for insured services; and the power of the minister and general manager of OHIP to collect and disclose patient information for any "purpose as may be prescribed." We want you to keep government's hands off our medical records. People have a right to some kind of confidentiality with their doctors, especially because we're afraid that this will open the door to further privatization of the OHIP

administration and the giving of our personal medical information to private corporations. After all, they might pay you something for it.

We're opposed to the amendment to the Health Care Accessibility Act that gives cabinet the power to make regulations that would permit hospitals to charge patient user fees for any hospital-based insured services, including those presently covered by OHIP. Examples of user fees would include accommodation and meals, necessary nursing services, laboratory and other tests, drugs and emergency room visits. Speaking of laboratories, we are also concerned about this tendency to move things into private laboratories, very often part of foreign-owned multinational companies that take away from our own hospitals the possibility of carrying out this work.

With the removal of the term "medically necessary," many services can be delisted. Differences could exist in the care provided by hospitals, independent health facilities and private hospitals. The government could easily differentiate on the basis of age, severity of illness and other criteria as the government determines in order to delist services.

Of course, you may feel that because I'm a senior I'm particularly sensitive to some of these things. Thus far, I've been fairly lucky. I'm 78 years old and I intend to continue fighting for a decent health system in this country. I hope you, if you live to be that age, continue to fight for something decent too.

The prescribed age groups clause is especially ominous. This could be interpreted to mean that the minister could decide that anyone over a certain age could no longer be treated for a heart bypass, or that a person with Alzheimer's could not be treated for pneumonia. The sad possibilities are unlimited, and what they suggest is the slippery slope to handling the problem referred to as the burden of an aging population. There is nothing in Bill 26 to prohibit such decisions. Under ever-increasing pressure to cut costs, and to get patients out of hospital, government officials and health care providers could make value judgements and even lethal "devalue" judgements based on age alone.

It's outrageous that the general manager of OHIP can refuse to pay an account submitted by a physician, practitioner or health facility if he has reasonable grounds to believe that all or part of the services were not medically or therapeutically necessary. This may mean that a family physician may refer a patient to a specialist because he or she believes the patient may have a serious condition. Then, if the specialist finds out that the patient is fortunate enough not to have that condition, the family physician could be liable for the specialist fee. Medical intervention for the comfort of those who are dying could also be deemed therapeutically unnecessary.

1650

Allowing hospitals to charge user fees for any hospital-based insured services, including those presently covered by OHIP, is a violation of the Canada Health Act. Most hospitals now have a financial situation with the capacity to identify specific costs and to charge user fees for accommodations, meals, necessary nursing services, laboratory and other tests, drugs, use of obstetrical delivery rooms, emergency room visits and so on.

The bill also authorizes an administrative fee of up to \$150 which hospitals may charge to patients.

These user fees are completely unacceptable and should be prohibited. People in this province who are poor, who can barely pay the rent and feed themselves certainly do not have \$150 to pay if they're hospitalized, especially since people with a marginal income also have a higher risk of illness and also have more frequent emergency situations.

Schedule H attempts to modify the concept of medically necessary services without any real public debate. It attempts to whittle down the services that are insured under the Canada Health Act. It's another route to two-tier medicine. Those who can afford it will buy insurance to cover whatever the Canada Health Act no longer covers, and multinational insurance companies such as Liberty Health—you've heard of them—are just waiting to move in.

The bill states that cabinet will not make regulations permitting charges for hospital services that contravene the existing act. Alberta is already demanding changes to the act that will give the provinces the flexibility to add new user fees. Is this the Ontario government's plan as well?

The Ontario Health Coalition also calls for the withdrawal of schedule G, which amends the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act of 1991.

Specifically, we oppose:

- Giving the power to cabinet to introduce user fees for drugs through copayments and deductibles for seniors and social assistance recipients. Everybody seems to forget that the copayment isn't just the two bucks they talk about, but it's also the \$6.11 dispensing fee and then of course the deductibles which start at \$100. History shows that what starts, ends up a lot bigger.

- Deregulating prescription drug prices that make Ontario the only province that does not regulate drug prices.

- Giving power to the minister to unilaterally determine which drugs will be listed and delisted on the formulary.

- Giving power to the minister to overrule the decision of a doctor or pharmacist as to what is appropriate medication by refusing to pay and by requiring the patient to bear the full difference in the cost between the approved drug and the prescribed drug.

- Authorizing the government to put itself above the law. In court decisions concerning generic drug companies, the bill states that the court decisions will have no force and effect. What the government couldn't win in the courts, the government is now seeking to override by legislation. Their contempt for the law is clearly obvious.

User fees are not cost-cutting measures; they are new revenue sources which hit the poorest of our society the hardest. User fees, deductibles and copayments for prescription drugs do not reduce the need for prescription medicine but they will reduce the number of prescriptions filled by seniors and families with limited incomes. It will increase the need for crisis intervention, hospitalizations, long-term treatment and other social services.

Supporters of user fees claim that the problems of drug costs are caused by the abuse of users in the program.

This is factually wrong. The escalating costs for the Ontario drug program come from overmedication, overprescribing and the high cost of drugs. User fees shift the blame for the high cost of the drug programs on to the victims—the seniors and those on social assistance—and does not put the responsibility on the perpetrators: the federal government and Bill C-91.

We don't want anybody to feel that we're only worried about what the provincial Tories do. We're also worried about some of the things the federal Liberals do. The fact is that what they have done, especially with Bill C-91, and the fact that some doctors have prescribing patterns that need revision, and above all the already high costs and profits of the drug companies, all add up.

In addition, the creation of a costly administration system to collect user fees will effectively distract energy and attention from real drug reform. The Ontario Health Coalition supports drug reform, not user fees. The way to improve health and save money is to control the way doctors prescribe and to implement a public education campaign. According to the Ministry of Health consultation paper on drug reform, 25% to 40% of all prescriptions are inappropriate. Each year, 17,000 people are treated for prescription drug problems in Ontario. That's why we think it's so important for seniors to have programs, so that they learn to handle the use and misuse of drugs.

Up to 20% of all hospitalizations for seniors are related to medication misuse or adverse drug reactions. Seniors in Ontario are prescribed far more drugs than seniors in every other province except Quebec. There is ample evidence that the high number of prescriptions is not from the Ontario drug benefit participants using the system but rather is a direct result of the prescribing patterns of doctors. According to the Senior Citizens' Consumer Alliance for Long-Term Care Reform, the Ontario branch of the Canadian Society of Hospital Pharmacists estimates that Ontario could save \$300 million from that program each year by documenting annual reviews of seniors' medication. As well, there'd be substantial savings if the high rate of hospitalization for seniors due to adverse drug reactions were reduced.

The Ontario Health Coalition acknowledges that some users' lack of knowledge on the use and overuse of certain types of medication also contributes to the cost of the program. However, a more viable approach to dealing with this issue is through education. An excellent example of this type of program is the Canadian Auto Workers retirees' medication awareness program in the Sudbury and Niagara areas, where seniors work with each other to learn the elements of responsible drug use.

The Ontario Health Coalition strongly supports the expansion of the current program to low-income persons not now eligible for benefits. No one should be denied medically necessary prescription drugs because of an inability to pay. However, this should be financed from reform in the drug program and not from the imposition of user fees.

I will now jump over schedule I, which you can read at your leisure, and move on to the final summary.

Bill 26 will irreparably harm the lives of every woman, man and child in Ontario. This bill is unparalleled in its

contempt for democratic processes, both in the way it was introduced in the Legislature and in the sweeping powers it gives to government. If this bill becomes a reality, it will have a negative impact on our neighbourhoods, devastate public services and destroy local democratic institutions.

During the election campaign, Mr Harris pledged that there would be no cuts to health care. Yet, on November 29 Harris announced that \$1.3 billion would be pulled from hospitals over the next three years. That's an 18% cut. If that doesn't give the lie to his election campaign, what does? He also promised he would not introduce any new user fees for health services. That's a clear lie too.

The omnibus bill gives the government permission to implement big cuts and user fees and impose many more, on top of the expenses that I talked about a few minutes ago of the whole idea of a new fee structure and so forth. The privatization and profitization of health care and the deregulation of drug prices point to more expenses, not less, a blind moving towards a US-style health setup, the meanest and most costly in the industrialized world, 40% more costly than any other country's; that's what it is.

The cumulative impact of the provincial actions, along with the federal destruction of our social safety net and the municipal implementation of the cuts, will have

catastrophic and far-reaching consequences for the people of this province. We know it will make life extremely difficult for the poor and the vulnerable, but it will also hit the middle class hard. For the past 50 years we've fought to equalize our society, and our achievements are at risk.

You have the responsibility of trying to suggest some way of improving this situation. Please don't come in with face-saving amendments that mean nothing. Saying you've put in an amendment so that something is only applicable for the next four years is a joke, but a sad joke.

All in all, this bill is an ideologically driven attempt to drive us back into the 19th century just when we see the 20th century ending. That's a heck of a note. It's an ideologically driven attack on 100 years of striving for a decent society of human and humane achievement.

We call once more on the government of Ontario to withdraw this bill.

The Chair: Thank you very much. We appreciate your presentation this afternoon. You've effectively used up all your time, so there's no time for questions. We stand adjourned until tomorrow in Niagara Falls.

The committee adjourned at 1702.

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

Marchese, Rosario (Fort York ND)

Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Caplan, Elinor (Oriole L) for Mr Sergio

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Johns, Helen (Huron PC) for Mr Danford

Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

Churley, Marilyn (Riverdale ND)

Crozier, Bruce (Essex South / -Sud L)

Kwinter, Monte (Wilson Heights L)

Leadston, Gary L. (Kitchener-Wilmot PC)

Martiniuk, Gerry (Cambridge PC)

McLeod, Lyn (Fort William L)

Wettlaufer, Wayne (Kitchener PC)

Witmer, Hon Elizabeth (Waterloo North / -Nord PC)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Fenson, Avrum, research officer, Legislative Research Service

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Legislative Assembly of Ontario

First Session, 36th Parliament

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Première session, 36^e législature

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LEGISLATIVE ASSEMBLY OF ONTARIO

STANDING COMMITTEE ON
GENERAL GOVERNMENT

Thursday 18 January 1996

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES
AFFAIRES GOUVERNEMENTALES

Jeudi 18 janvier 1996

The committee met at 0901 in the Sheraton Fallsview Hotel, Niagara Falls.

SAVINGS AND RESTRUCTURING ACT, 1995

LOI DE 1995 SUR LES ÉCONOMIES
ET LA RESTRUCTURATION

Consideration of Bill 26, An Act to achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the Government's Economic Agenda / Projet de loi 26, Loi visant à réaliser des économies budgétaires et à favoriser la prospérité économique par la restructuration, la rationalisation et l'efficacité du secteur public et visant à mettre en oeuvre d'autres aspects du programme économique du gouvernement.

The Chair (Mr Jack Carroll): Good morning, ladies and gentlemen. Welcome to the standing committee on general government hearings on Bill 26. We're happy to be in Niagara Falls this morning on a beautiful, almost springlike morning. It's nice to see Niagara Falls in the wintertime.

We have a couple of housekeeping things to attend to first before we call our first witness, so we will start with those. Mrs Caplan.

Mrs Elinor Caplan (Oriole): Before the motion is placed I do have what I think is a point of order; certainly it's something that is disturbing me. Yesterday, Mr Clement, when we had the government error in having amendments released first to the media, said that those amendments were housekeeping amendments. Mr Chair—man, they are not housekeeping amendments.

The first amendment, when you take a close look at it, deals with the powers to the commission. What we have heard from delegation after delegation is that the minister shouldn't be delegating powers to the commission, and in fact that amendment allows him to delegate further powers and greater powers to the commission. I'm very concerned that this committee and the people who were here yesterday have been misled. I would ask Mr Clement to correct the record today at the start of this hearing that those in fact were not housekeeping amendments. While they may not have been significant in the context of the bill, they certainly were not housekeeping.

The Chair: With all due respect, Mrs Caplan, that's not a point of order.

Ms Lankin, you have a motion?

Ms Frances Lankin (Beaches-Woodbine): Yes, I have two motions. My first motion is with respect to extension of the public hearings, and it reads as follows:

Whereas this is the final day remaining for public scrutiny on Bill 26 in this community; and

Whereas there has been public interest in this bill which has been overwhelming; and

Whereas the vast majority of presenters to the standing committee—

Actually, I think I've been given the wrong copy here. Tonia? Sorry; that was why I was looking back and forth. I'm going to move to another motion, because the wrong copy's been provided, so I'll come back to that one.

Whereas there are only two days remaining for public scrutiny on Bill 26; and

Whereas the public interest in this bill has been overwhelming; and

Whereas the vast majority of presenters to the standing committee on general government have recommended major changes be made to the bill; and

Whereas the amendments tabled on January 17 only pertain to schedule F;

I move that this committee recommend to the government House leader that the 84 individuals and groups that requested to appear before the standing committee on general government in Niagara Falls be given the opportunity today to see the government's amendments to schedules A, B, C, D, E, G, H, I, J and K and the remaining amendments to schedule F of Bill 26.

The Chair: Thank you, Ms Lankin. Out of respect for the people who are here to make presentations, can I have all-party approval for just one-minute comments, one from each party, on this motion? Agreed. Ms Lankin.

Ms Lankin: Mr Chair, as you know, I have been requesting virtually every day that the government table its amendments to this bill. It is, to my way of thinking, absolutely unacceptable that the government has indicated areas where it intends to make amendments, it has told presenters that as early as the first day of the public hearings—December 18, in Toronto, the minister indicated areas that he was going to amend—and through that whole period of time we have not seen those amendments. So presenters come forward and they continue to make points on parts of the bill that the government intends to amend, and the presenters and the opposition have not had the opportunity to understand what the government's intent of amendments is with respect to any parts of the bill and/or to make comment on whether those amendments go far enough to address the concerns that have been raised.

As you know, we begin clause-by-clause analysis of the bill on Monday. This is down to the wire in terms of presenting the amendments and people being able to understand them and being able to respond to them in an informed fashion. I fear we have a complete replica of what we had when this bill was tabled: an intent to ram the changes through without proper public scrutiny,

certainly without any public scrutiny in terms of the amendments, and without proper time for analysis.

Let me just wrap up by saying that we received seven amendments yesterday from the government, a couple more in the afternoon. They're very minor amendments. They don't go far in terms of addressing the concerns that have been raised. I suspect we'll see some more today and tomorrow. This is a totally, totally unacceptable way to proceed. I implore the government members to table all of their intended amendments today.

Mr Tony Clement (Brampton South): I must speak against the motion. Forgive me, Mr Chairman, if the tone in my voice does evidence some frustration. We have been hearing from the committee members that they wanted to see amendments. We have given them our undertaking that we would table them as soon as we felt comfortable that they reflected the government's position, based on what we heard from the presenters. We wanted to allow the committee the time to hear from as many presenters as possible, to show them the respect they deserve and require that their views are important to us. We felt we had come a long way in doing so with our amendments to the hospital restructuring which we tabled yesterday.

Quite frankly, we are not going to table amendments until we feel comfortable that we reflect what we have heard from this committee and have shown the presenters the respect that is due to them, but also that they reflect the need for this government to do its bit to get our spending under control and also to reinvest some of the savings into the health care sector, which is direly needed. I'm not going to be precipitous and table amendments until we are quite convinced that they are the amendments that are needed for Ontario.

Mrs Caplan: The entire way that the government has handled this bill from day one, both in the way they presented it in the Legislature when we were in a lockup, to the way they are changing procedure about tabling amendments—we've said to you it is tradition in this House that you table amendments quickly—

Mr Clement: That's what we're doing.

Mrs Caplan: —so that people who come here can know what your intention is around changes. You'll always have the right, as the government, to table additional amendments as you listen to people and they influence you for further changes. But to say to them, "We're not going to let you see what we're thinking about," even in the form of a draft amendment tabled, is the height of arrogance and it is typical of the process that we have seen here where you're closing people out, you're not letting them be heard. You wanted this entire bill, without amendment, passed before Christmas.

I'll tell you something: The people of this province are not going to let you get away with this and they're not going to forget it. If you don't table those amendments today, it is inadequate time for people to look at them. That's not the way to run a government.

Ms Lankin: Earlier in the week, at one point in time, Mr Clement said he had sympathy with some of the points I was putting forward. Let me say to you today, with due respect, I have no sympathy for the fact that you feel frustrated. If you think you feel frustrated, how

do you think the people who won't have a chance to be heard today in Niagara Falls feel, all of the people who have applied in cities across this province who are not being heard by this committee because this government insists on ramming through this process and getting this bill passed by January 29? How do you think people feel who don't know what it is you're going to pass the end because you refuse to table the amendments and show us what the amendments are?

I got a commitment from the Minister of Health that those amendments would be tabled in a timely fashion. I asked for them before we went out on the road so the public knew in fact what you were intending, and the opposition knew. Yesterday, we had the spectre of seven amendments being tabled and then, surprise, surprise, we find out that the media have got additional copies and we have to raise points of privilege. The government files the additional copies with us, makes apologies and says, "But they're only housekeeping," and as we look at them in the afternoon we find out that there is a major, substantive amendment which runs absolutely counter to the presentations we've been hearing.

Mrs Caplan: Absolutely.

Mr Clement: Not so. Not so.

Mrs Caplan: It is so.

Ms Lankin: We would not have had that before us yesterday if it hadn't been that a member of the media had those. Take a look at the paper this morning. You can see that the Toronto Star yet again, day two, has amendments and knows what's coming before members of the committee have been presented them and before the public has a chance to see it. This is an unacceptable process. It continues the arrogance of this government in ramming things through without public scrutiny and without democratic debate. You should be ashamed of yourselves. And if you're frustrated, let me tell you, the rest of us are just fed up.

Recorded vote, please.

0910

The Chair: Ms Lankin has requested a recorded vote. Just for the information of the audience, there are only five people at the table with the right to vote, so they will be the ones casting a vote.

Ayes

Caplan, Lankin.

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated.

Mrs Caplan: Could the clerk try and get some more chairs, Mr Chairman?

Interruption.

The Chair: I'd just like to make a couple of comments here. Basically, we only have a short period of time to be in Niagara Falls to listen to people from Niagara Falls.

Mrs Caplan: Extend the time.

The Chair: We would very much like to hear from the presenters who are scheduled, so I would ask that we not waste a lot of time. A minute is a minute, folks, so try to keep it to a minute, please. Ms Lankin.

Ms Lankin: Mr Chair, you just addressed the reason for my second motion. We only have a short period of time to be here in Niagara Falls. So:

Whereas there has been overwhelming public interest in Bill 26 and that 39 groups and individuals have requested to appear here today before the standing committee on general government in Niagara Falls, which far exceeds the 15 spaces available today for hearings;

I move that this committee recommends to the government House leader that when the House returns on January 29, 1996, that the order with respect to Bill 26 be amended and that the bill be returned to the standing committee on general government so that further public hearings can be arranged for the community of Niagara Falls;

Further, that this committee recommends to the three House leaders that they meet as soon as possible to discuss these issues.

I think the reason for this motion is painfully obvious. This week and last week two committees are travelling this province, to cities. We have had over 1,000 applicants, groups and individuals, who requested to appear before the standing committee. There are fewer than 300 spots available for people to be heard.

Virtually every day we learn something new about this bill. We've been through it and through it and through it, and yet we still find out when people from the public come forward that there are unexpected implications of aspects of the bill that we didn't know about as legislators or that we couldn't have foreseen without hearing from the public. That's what the process of public hearings is about.

You have taken the most unprecedented scope and depth and breadth of legislation, strung it all together in what you call one bill—it's really about 15 or 16 different pieces of major legislation—and you're trying to ram it through in a time period that doesn't allow public scrutiny, doesn't allow full understanding, and as we can see, you won't even give us the amendments to tell us what it is you're intending to do.

I'll just wrap up by saying this motion simply recommends from the committee that the government House leader take a look at this issue. It doesn't bind the government House leader; it doesn't force him to do anything. I would implore the committee members, if they're truly listening to what people are saying, who have said over and over again, "Slow this process down," to please support this motion today.

Mr Clement: I will speak against the motion for the, I believe, tenth straight day. As I said on previous days, this is a bill that will have had by the end of tomorrow 750 separate presentations from the public, with differing points of view, with a multiplicity of points of view on this issue. We have heard the gamut of points of view on this. This bill has had more committee time than any other bill in the previous two parliaments in the last 10 years to discuss with our communities throughout the province of Ontario and in Toronto: more time than any other bill in the previous two parliaments.

Mr Peter Kormos (Welland-Thorold): Tony, we don't believe you and neither do they.

The Chair: Mr Kormos, Mr Clement has the floor.

Mr Kormos: I understand that but—

Mr Clement: Ms Lankin talks about what the people demand. We have heard demands at this committee that the government be given the tools to act—

Mrs Caplan: Even the chamber of commerce told you to slow down. Even the businesses told you to slow down.

Mr Clement: —the tools to restructure the health care system so that we can reinvest the savings in the type of health care that Ontarians need.

Mrs Caplan: Everyone has told you to slow down.

Mr Clement: And quite frankly, if we hold off even for an extra month, it means \$720 million more on the debt, more out of health care, more out of crime prevention, more out of education.

Mrs Caplan: That is a lie.

Mr Kormos: We don't believe you.

Mrs Caplan: You are lying, Tony, and you know it.

The Chair: Excuse me. You've got a choice. Do you want these people to spend the day arguing or do you want to be heard? I think we're here to hear you, not to hear these people argue with one another and take political postures.

Interjections.

Ms Lankin: Oh, come on, Mr Chair, chair the meeting.

Mr Clement: I was interrupted, Mr Chair. If I can wrap up my remarks, for a group of parliamentarians who care so much about democracy, to shout me down is the height of anti-democratic behaviour.

Mr Kormos: Oh, please.

Interjections.

Mr Clement: You should be ashamed of yourselves.

The Chair: Mr Bradley.

Mr James J. Bradley (St Catharines): Thank you very much, Mr Chairman. Speaking in support of the motion, this is a motion which the two opposition parties have endeavoured to have passed in some form or other across the province, and it's become increasingly clear to those of us who have observed the results of these hearings that there are a lot of people and a lot of organizations out there that wish to make further representations. The bill, though not worthy of support because of its general concept, already will have been improved marginally as the result of those representations.

I appreciate the history lesson from the newly elected member for Brampton South. In my 18½ years in the Ontario Legislature, I have never seen a bill so complicated and a bill so extensive and a bill that requires these kinds of hearings for more than the allocated period of time. As the House leader for the official opposition, for the Liberal Party, I can assure you that I, as one of the three House leaders, will willingly agree to an extension of these hearings and will endeavour to persuade the government House leader of the wisdom of extending these hearings so that this legislation can be appropriately amended, or perhaps withdrawn, as a result of those representations which are made.

I think this is a very sensible motion, as the others have been. I think it's worthy of the support of all members of this committee, and I hope the Conservative members will join the two opposition parties in trying to improve the legislative process at Queen's Park.

Ms Lankin: Mr Chair, if Mr Clement is any indication of the other government members of the committee and their feelings about what they've heard in these public hearings in saying that people have been coming forward and saying the government needs these tools, the government has to proceed, the government needs this legislation, then I have no faith that we will see amendments come forward that reflect the public interest and what the public concerns have been.

Virtually every group that has come forward has been in opposition to many parts of this bill. The very few groups that have come forward that have said they support the intent of the bill have then gone on to list a whole bunch of things that they think need to be amended and changed. No one has given the kind of unequivocal support that Mr Clement would have this committee room believe. It's a shame that he would present it that way, and it makes me believe that this government committee has not been listening at all to the people of Ontario.

I urge the members to take another look at this, to support this motion, to realize that people want a government that is democratic and that is prepared to listen to the people. That is all we are asking for: for you to listen, finally; to listen not to us but to listen to the people.

Recorded vote, please.

Ayes

Caplan, Lankin.

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated.

Mr Kormos: On a point of order, Chair: When is a public hearing not a public hearing? Firstly, when those people who want to participate in that process are denied access to it. Secondly, when they're not even admitted into the room because the chambers that are selected are not sufficient to contain interested members of the public.

Further to my point of order, this committee is meeting tomorrow in Hamilton. It's going to be bused to Hamilton, which I can tell you is a 45-minute bus ride. They're going to be contained in accommodations there overnight. In view of the fact that they're all well-paid people, in view of their salaries, especially their just-shy-of-\$100 per diems, perhaps this committee could extend its sittings today through the evening to at least 9 o'clock to accommodate a few more of those people and groups that have wanted to make presentations. They're ready, willing and available. Some of them are sitting right here.

It is repugnant that public hearings cannot accommodate the public in terms of physical space, and equally repugnant that well-paid members of this committee can't do a little bit of overtime, which is what a whole lot of hard-working people in this region do on a regular basis to try to support their families, to accommodate people.

0920

I can't think of any reason why this committee cannot sit through until 9 o'clock this evening to hear these people. As I say, it's a 45-minute bus ride, and if people are worried about becoming overly tired, I'll make sure

they have comforters on their beds at the Royal Connaught, or wherever the hell it is they're staying in Hamilton tonight.

I'm urging a member of this committee to move, first of all, that more chairs be brought into this chamber. There's space for seating. There are some people here who are seniors, among others. Secondly, I'm urging a member of this committee to move that this committee extend its sittings today through to 9 o'clock, and that the clerk immediately start contacting those groups on the remnant list of people who were denied access, so that they have a modest opportunity to provide some input to a very, very important process.

Ms Lankin: I so move.

The Chair: What was the motion, Ms Lankin?

Ms Lankin: The motion is, first of all, that chairs be brought into the room to accommodate the people who are now standing and want to attend through the day to listen to these public hearings and, secondly, that the sitting of the committee be extended to 9 o'clock tonight and that the clerk be asked to contact those groups who requested but were denied standing, and schedule groups through into the evening for the committee to hear.

The Chair: We asked for more chairs to be brought in. Unfortunately, there's no place to put them.

Out of respect for the people who have come to make presentations to our committee this morning—we've already taken up almost a half-hour of the time—could I ask for all-party approval to discuss that motion at lunchtime?

Ms Lankin: Mr Chair, if you leave it to lunchtime and the committee passes that motion, there will not be time to contact the groups. I'm prepared to proceed to a vote.

The Chair: Are you prepared to proceed to a vote with no discussion?

Mr Clement: Don't we get to discuss it?

Mr Kormos: Go ahead, discuss it.

Ms Lankin: If you would like to, Mr Clement, then we should discuss it now. I don't need to make any more comments. My colleague has put forward the reasons. I don't need to add anything else directly.

Mr Kormos: Don't discuss it in private. The bill was developed in secrecy. At the very least, these discussions should be held publicly.

Mr Clement: Proceed to a vote.

Ms Lankin: Recorded.

Ayes

Caplan, Lankin.

Nays

Clement, Ecker, Johns.

The Chair: The motion is defeated.

Mr Kormos: Don't you know what it means to work a little bit of overtime?

Interruption.

The Chair: I'm going to tell you something, folks. It is impossible for me as the Chair to conduct these meetings in this kind of an atmosphere.

Interruption.

Mr Kormos: You guys are arrogant and you're lazy.

Mrs Ecker: Don't you dare—

Mr Kormos: A \$100-a-day per diem, shame on you, and you won't work past 5 o'clock.

The Chair: We're going to recess.

The committee recessed from 0923 to 0925.

The Chair: Are these all witnesses sitting at the table?

Mr Kormos: They are now.

Interruption.

Mr Kormos: All of Ontario is a witness to this disgraceful bit of stuff, I'm going to tell you, Chair.

COMMUNITY ACTION PROGRAMMES, NIAGARA

The Chair: Our first presenter this morning is Robert Wright from the Community Action Programmes. Welcome to our committee, sir. Questions, should you leave time for them, would begin with the government. The floor is yours.

Rev Robert Wright: Thank you, Brother Chairperson and sisters and brothers on the committee, the local MPPs. It's good to see Mr Hudak and Mr Bradley and Mr Kormos from this area again. Last week we were here and had, I thought, some very fruitful discussions take place. My name is Robert Wright. I'm a community outreach minister and a community development worker with the Community Action Programmes and REV Ministries.

I might say also that I'm an Aries. I read my horoscope this morning and it says: "In the end, you will do what your conscience tells you, but for a while you're tempted to do otherwise. You also could be asked to give some advice. Consider your words carefully." I've been rapidly revising my presentation during the interim.

I wish to thank the organizers of this event for giving me the honour of welcoming the members of the standing committee to this Niagara region. I've prefaced the report with some quotes from two of the political leaders, and I apologize to the leader of the Liberal Party. If the members of the Liberal Party would pass that apology on to her, I would appreciate that. I didn't pick up any recent quotes in the paper from her and you might inform her that it's not necessarily a liability not to be quoted in Juxtaposition.

I also want to apologize to the New Democrats for misspelling the name of the leader of your party, although perhaps we are to see some rays of sunshine. Perhaps Mr Kormos would even be willing to turn over his title as Sunshine boy in exchange for Mr Rae turning over his mantle to you.

In many ways this region presents a microcosm of Canadian life, yet it also has many unique qualities which we believe can be of benefit to and provide many insights for the rest of this province, for our country and indeed for the world.

My presentation is going to be somewhat general in nature. Other presentations today will, I'm sure, be dealing more specifically with the issues involved. In the time I have, I intend in this presentation to offer some reflections on the context within which we find ourselves at this time in our history, a bit about how I perceive we got here and some suggestions for future directions.

These reflections will also be something of a transition, here at the beginning of the morning, between last week's more general discussion and this week's focusing particularly on health care aspects of Bill 26.

0930

Right at the beginning, I want to affirm that it is my very carefully considered opinion that the passage of this omnibus bill on January 29 would be a major error, that it should be split up into manageable sections and that there should be widely varied opportunities for intense consideration of these issues by as many citizens as possible within their communities. I recognize that such action might be perceived by some as a failure of nerve on the part of the government. However, as a pastor and as a person with many years of involvement with people and communities and their development and growth, I personally feel that it is a sign of strength to be able to revise plans we have made and to back off a bit from precipitous action. I think whether we think the amendments which have been proposed are significant or insignificant, it is significant in itself that these are to be brought forward. It shows a willingness to be flexible, and I would urge you to be more flexible.

I also feel it is of utmost importance that the process followed should be to the greatest extent possible without the limitations imposed upon us by narrow partisan political posturing. The issues are far too crucial for us to take inflexible stands which do not have the wellbeing of the populace at large as the motivating factor.

Perhaps I can illustrate this point more clearly by referring to an experience we had in this Niagara area with the establishment of a group we called the Working Future Coalition, which brought together representatives of business, community groups, government and labour to look at common concerns, especially around the local economy. I think that regardless of what our political position is, we have to say that previous governments have followed that attitude, not only the New Democrat government which just went out, the Liberal government before it and the Progressive Conservative government which was in power in this province prior to that.

The successes of the Working Future Coalition were very modest—some would say almost undetectable—yet we did find that when a real effort was made to listen attentively to one another for the wellbeing and the common good, we did make real progress in bringing the community together in this way.

In the spirit of that, the method I used in preparing this brief was myself to get out and speak to people in doughnut shops, in seniors' residences, seniors' meetings, meetings of young people and various groups. While all of their comments are not contained within my presentation, they have had impact on what has been put in here and I urge the committee to follow that kind of method in pursuing the work which has been set before you.

The concept of wide-scale community involvement in decision-making was a major aspect of the election manifesto which swept the Conservative Party into power last June. That manifesto also stressed the need for sacrifices to be shared equitably by all sectors of the population.

My personal observation of the reality which confronts us is much different. It seems to me that it is those who are at the bottom of the economic scale who are suffering most. I do not see any evidence that those at the top are sharing in the necessary sacrifices. I read the business section of the newspaper religiously every day, and I see profits of banks and other large institutions continuing to skyrocket. I see CEOs' incomes continuing to rise. I ask, what sacrifices are they making, from a base which is much more secure and prosperous than those at the bottom? And I don't ask that just rhetorically. I ask it because I want to know. If you do know of sacrifices which are being made by those people, please tell us.

Instead of sharing in the extreme suffering which is being experienced by so many lower-income working people, we see the people at the top being subsidized by our tax money in many ways. For example, there's been a lot of publicity around Team Canada's trip to Asia—Mr Harris, Mr Chrétien and the other premiers—in order to get trade deals for big corporations. I personally do not see how that expenditure will help those of us in the lower-income levels. Instead, why are those who are going to benefit from these trade deals not paying for that trip? Think of all the other places where our money could be spent in reducing the deficit and improving the quality of life of the average Canadian.

Similarly, can anyone tell me how much is spent on food and health care for the average prisoner in our correctional institutions? How do these amounts compare with the recommended budget for welfare recipients or for actual expenditures received for our health care?

It is very difficult for those at the bottom to see common sense in cutting off the people's purchasing power, cutting out jobs and reducing significant services such as health care. Who is hurt, beyond those whose income is cut back and whose jobs simply disappear? It is becoming increasingly obvious that it is small business people, the workers, employed or unemployed, organized or non-organized, and so on now increasingly up into the middle class. Already business people in corner stores, barbershops, hardware stores and doughnut shops are feeling the pinch. I have spoken this week to two doughnut shop proprietors who have told me their business dropped dramatically, as soon as the government cuts were announced. How is it common sense to take money from people who will spend it immediately within the community and instead turn it over to those who will in most likelihood not be spending it here in Canada?

According to a recent report, in Europe it is being said: "Communism failed. Capitalism isn't working. We have to try a third way." Fortunately, in Canada we have had a third way, and it has worked. It has been a glowing example to the world, in countries like our own, in the Scandinavian countries and many parts of the developing world and elsewhere. We have proven that there is a third way and we are the beneficiaries of that third way, which many of us and our forebears have struggled to build. The guiding principle is that we do not have to be inexorably controlled by the marketplace, driven as it is by the need of the giant transnational corporations to amass greater and greater monetary wealth. By putting checks on powerful financial institutions, we have been

able to avoid the depth of the previous Great Depression, which many of us remember so well but which many of us feel is rapidly coming upon us again. Our heritage is in great danger of being destroyed.

Recently, I discussed some of these issues with a group of young people. They were very charming; they were very affable. They quickly recognized that the rhetoric we hear is true, that a household must balance its budget and cannot go on forever running on deficit financing. They know that from their own families, their own homes. They hear it from their parents all the time, and they realize it's true.

But they also realized, as one person put it, that a family or a household which would cut out spending on food for the children or risk losing the breadwinners' jobs while continuing to buy beer would be seen as a very dysfunctional household or family. Isn't our society becoming very dysfunctional, very unhealthy, as we continue to take from those who are already overburdened and transfer their modest means to those who are already far more than adequately endowed with resources of wealth and power?

After the Second World War, the welfare state developed very quickly, and I can remember those days very well. I was a teenager at the end of the Second World War and I was caught up in the excitement of reconstruction. The decision of the society we were building was not to go back to being ruled by mean and brutal free market forces. The idea was to have a balanced economy, with private, cooperative and public sectors all working together in harmony. Units would be kept small and as close as possible to direct control by the people working together in communities.

A public health plan was a major requirement of this movement. It was recognized that a healthy society requires that individuals have maximum opportunity to enjoy good health, and people from all parties—the CCF, as it was then, the Liberals and the Progressive Conservatives—all joined in that effort. How would we pay for it? We would pay for it partly as any other insurance is paid for: in advance. We would also pay for it by better health, resulting in reduction in costs.

0940

Just the other day I read an article which reminded me of a fact I have known since the days of the Second World War and postwar reconstruction. The seniors who have joined me here at the table will also remember this. We came out of the Second World War with a big debt, for those days. We had operated on deficit financing and needed to pay off our debts from the Second World War.

We were able to do so relatively quickly because we had a full employment economy; everybody was working. That has to be driven home all the time: because we had full employment, not like now, because the less employment there is, the less there is paid in taxes, the more we have to go into deficit financing, and it's a vicious circle.

Debt we owed was largely to ourselves. I bought war savings stamps, which I turned into war savings certificates, and when I cashed those in, I bought my first bicycle. Everyone was involved. We were in debt but we owed it to ourselves, not the gigantic financial institutions

outside our country. And everybody was willing to sacrifice. I don't want to overromanticize this. There were some who took advantage of this. Some of the powerful people in our society, we discovered later, were milking the system. You talk about welfare bums, these corporate welfare bums should have been brought up in the war crimes trials.

The other thing was this: that because we knew the public sector, the private sector, the cooperative sector, could all cooperate together, we weren't afraid of public ownership. We weren't afraid of community or cooperative ownership. We recognized that all of those ways have a valid part to play.

A vital aspect of a truly effective health care plan, to address that topic in particular, is that it be administered as much as possible by the people themselves, that it be subject to their control and that it not be the preserve of vested interests which seek to get rich off the ill health of others. All of us who are of my age in this room can tell stories from before the time when we had a health care plan where we were robbed because of the fact that we didn't get proper health care and society as a whole suffered for that. It's also vital that health promotion and prevention of disease be items high on any agenda.

Now we are told, however, that our achievements have to be sacrificed on the altar of deficit reduction, yet it was not we who ran up the debt or the deficit. We have been productive citizens all of our working lives. We have paid taxes in order to enhance the quality of life for all of us. As with all other insurance which we carry, we hope never to have to draw on our health or unemployment or other social insurance. We did it for those less fortunate than ourselves, an investment for the wellbeing of our children and our grandchildren and of society at large.

Now we find that those very programs in which we invested—and it's our money, remember—are being wiped out, and with them is being wiped out the safety of the most vulnerable in society, without any consultation by those of us who are directly affected. In fact, Bill 26 removes control farther from those of us who have paid for these services. Again, I find it very difficult to understand where the common sense is in that.

Bill 26 goes in exactly the opposite direction to what is needed in our society. We see power being centralized in the hands of the minister instead of being disseminated among us. At the same time, legislation is being put in place to override the will of the people, to wipe out citizen boards, which are a major part of the process of making democracy as directly accessible as possible.

Last Thursday, Lord Acton was quoted, "Power corrupts, and absolute power corrupts absolutely." I would add to that one of my teachers, the theologian Reinhold Niebuhr, who said, "Because of the sinful nature of mankind, democracy will never be perfect, but because of the sinful nature of mankind, democracy is absolutely imperative."

Perhaps I can make an analogy with the process which took place in the Ministry of Housing, with which I was working prior to being laid off because of the cuts, where a program was put in place called Planning Together. The motivation for this program was the idea that tenants

have a right and a responsibility to participate in decision-making which affects them. With greater participation, my friends, comes greater responsibility, and with greater responsibility comes greater efficiency and effectiveness. People see why it is logical, why it is common sense not to be wasteful, because what is wasted here and now will not be available when it is needed elsewhere later on.

We have built the welfare state well. Let us recognize that. In Canada the welfare state is a shining example to the rest of the world. It enshrines one half of the equation: our rights—to each according to need. Every human being has certain inalienable rights, simply because we are human. But we must now go beyond the welfare state to a new type of fully cooperative living. The fundamental emphasis on rights must be coupled with an equally important emphasis on responsibilities.

The wealthy have a responsibility to provide for the poor. When we are recipients of society's largess, in whatever form—financial, spiritual, emotional or intellectual—we have a responsibility to return in whatever way is appropriate the skills, talents, training, wealth which we possess, and that was happening within the Ministry of Housing in this Planning Together program. Industries which are built on the resources, human and natural, in our society are responsible to return a generous portion of that which they have been given out of the wealth of the nation to enhance the wellbeing of all. From each according to ability is the other half of the equation, and I'm quoting Karl Marx but I'm also quoting the book of Acts in the New Testament.

Prior to the establishment of a national health insurance program, the Hall commission held hearings across the country. Various faith communities, including my own denomination, the United Church of Canada, presented briefs to that commission. I was privileged to be involved as one of my denomination's representatives in preparing that presentation. Appended to the brief which the United Church made were many pages of statistics, but those were placed along anecdotal evidence compiled by a group of clergy serving in a wide variety of outreach ministries—in financially depressed urban and rural areas, on Indian reservations and in traditional middle-class communities where there was hidden poverty behind the pleasant lawns and shrubbery.

It was concluded that it was to the economic advantage of all Canadians to establish a Canada-wide health care scheme. We now have that. It is far from perfect, and the imperfections lie in the tendency to have the pyramid with power at the top. That power has to be disseminated and brought to the people. It is far from perfect but it will be improved only by decentralizing power and decision-making, not by concentrating power and decision-making, as Bill 26 proposes, nor by shortsighted cutbacks in funding. I might make the point that this is not a partisan position. This is a conservative position, a progressive conservative position.

It is particularly in regard to long-term programs of health awareness and promotion, which include early detection of disease, that effective programs of prevention can take place, in the long term saving us all significant funds. Certainly this requires initial investment, although

it is minimal compared to treatment after disease has developed. That's much more expensive. These programs, especially for children—and I emphasize the importance of stopping the cutbacks to children's programs, because that is going to have an impact very soon and for generations, for decades—pay huge dividends, both directly in financial savings and long-term in building healthy communities.

In regard to confidentiality of medical records, it's imperative that these be regarded as a sacred trust. If we are interested in prevention, we must take with utmost seriousness the importance of confidentiality. As one who has been privy to the privacy of the confessional—although we Protestants don't term it that, in point of fact that's what it is, the absolute privacy of the confessional. We have learned in the case, for instance, of prevention of the spread of venereal disease, its reduction and, we would hope, eventual elimination, that people must feel free to approach physicians without the fear of rules of morality being imposed on them. They have to feel free to come in confidence. The same applies with regard to various emotional or mental illnesses where a deeply perceived threat inhibits effective recovery or cure. Medical records must be totally confidential, and I am pleased to read in the papers that it appears that that is going to be respected and recognized.

0950

I had an additional comment from a nurse. I didn't have a chance to integrate it into the presentation today, but she pointed out that one of the problems we have is overmedication. Physicians tend to prescribe more than is necessary. As we talked, she said, "Maybe, because there is a need to bring that under control, user fees would be the way." But then, as we talked, she said: "No, that wouldn't work. User fees prevent the people who are most needy from acquiring that medication."

What we did talk about is a program that the CAW, I know, has instituted where they are working through their retirees membership in order to find out what medication retirees are using now, where they are overmedicated, and to show them alternatives, and that's a much better way of doing it, I believe.

All right. As for the proposal to move doctors around to more needy or remote areas, it would seem that the concept has some merit, but the way in which Bill 26 proposes it be implemented seems to me lacking in common sense. I suggest an alternative from my own denomination's point of view. The more such programs can be achieved in conciliar rather than adversarial fashion, bearing in mind special needs and responsibilities such as family commitments, the more effective and rewarding they will be for all involved. The more coercive and forced, the more it will be a bitter experience for all.

To take up Mr Rae's challenge, which I quote on the front, congratulations and thanks to all the workers. That includes all of us, the members of the committee, the visitors who are here today—and the attendance here shows what a great concern this is to everyone—workers with hands or brains, in management or on farms, in factories or offices, employed or unemployed, male or female, on whose contribution to our common wellbeing the good life we enjoy depends. Let us all give ourselves

and one another a pat on the back. Let us celebrate the great things we have accomplished and let us, above all, be careful lest we throw out the baby with the bathwater.

I thank you, the members of this standing committee, you who are our employees, the MPPs from this region who are in attendance here today, also our employees, the media who give us access for our views to the wider public, and especially the members of the staff who today have facilitated the behind-the-scenes work of bringing us together for this important occasion.

I do encourage you to report back to Mr Harris and the cabinet that, in all honesty, you feel that passage of this Bill 26 on January 29 would be precipitous and ill-advised, that because of the great importance of the issues involved it is imperative that there be much greater opportunity for widespread consultation.

I apologize for the length of my presentation. I want you to know that I spent some time, a year and a half, in Jamaica with the United Church there and I discovered that there is a different attitude in the church in Jamaica than there is in Canada. If you didn't have a two-hour church service, the people didn't feel they got their money's worth, so I've erred on the side of being overloquacious. But thank you for listening.

The Chair: Thank you very much, Reverend. We appreciate your presentation this morning and your interest in our process.

Mr Clement: Mr Chairman, can I table for the committee's benefit some answers from the ministry to questions that have been raised by members of this committee?

The Chair: Thank you, Mr Clement.

DEPARTMENT OF OBSTETRICS, ST CATHARINES GENERAL HOSPITAL

The Chair: Our next presenters are from the department of obstetrics of St Catharines General Hospital. Good morning and welcome to our committee.

Dr Heime Geffen: I'm Dr Heime Geffen. I'm chief of medical staff at the St Catharines General Hospital. My role here is merely to introduce the speakers who represent the physicians who practise obstetrics at our hospital. We also have with us a patient who's going to give us her viewpoint. Carolyn Ioannoni is the patient, who will be speaking first.

Mrs Carolyn Ioannoni: Good morning. As I sit here, I'm looking behind me and I see a majority of a room full of women who at one point in time had to have obstetric care. Every day we read in our newspapers our lack of obstetrical doctors, who are leaving town. There's not one of us who cannot at this point in time appreciate the fact that these men are greatly needed. We need an even larger number of women to be practising obstetric care, but what we're reading daily is that our doctors are leaving.

There is no incentive to bring doctors to our area. Every day we read in our newspapers in Niagara Falls this severe lack. There are patients who are going to clinics because they don't have their own family physicians. What do they do when they're pregnant? Where do they go to get the proper care they need?

I'm a mother of three, ranging from 11 to 5, and I've had fantastic obstetric care. The first two children were born through an obstetrician, the third through my family doctor, Valerie Bayley, who is wonderful. I had as excellent care with my family physician as I did with my obstetrician.

In St Catharines at present there are only five obstetricians to handle a caseload of approximately 2,300 pregnant women. As we all know, pregnancy is a time of joy. It is also a time of stress, worry whether we will get the proper care and, as everybody here knows, there's no dignity in giving birth. There is absolutely none.

You can only hope that the person who you have gone to for nine months will be the person you end up in the delivery room with, because the fear and the trepidation of having a strange doctor deliver your child is overwhelming. This is not the person you have bonded with for nine months, who has listened to your problems. With five doctors handling this size of a caseload, you are not guaranteed your doctor.

We have another doctor leaving February 1, Dr Chan. That even lowers the number of obstetricians we have. This is an essential service. This is not something that can be thrown away and not looked into. We need these doctors. We need to bring incentives to our area to bring them here.

Reading your bill, I do not understand why anybody these days would become a doctor, let alone stay a physician. You are hindering them greatly. I've read that doctors stay in it for the money. That can't be. I've watched them, I've sat in offices. They have to do it out of sheer dedication, out of sheer will to want to help. As women we have to have the obstetric service, and the men, who don't, are pushing away the essential service that we all need.

I would like to be sitting here in front of you in maternity clothes, and if this session had been done last week, I would be. I would have been in my second trimester. Unfortunately, I miscarried last week and I was able to have top-notch obstetrical care. Dr Valerie Bayley helped me and I was lucky enough in the short span of time to get Dr Cheema, who assisted me and performed my surgery. Not only did I get great surgical care, I got great support care. Anybody who has gone through it or is going to go through it knows this is the care we need. This is not optional; we need it.

I beg of you to look into your agenda. This is not going to help anybody. One of our doctors wrote a letter saying our unborn children are at risk, and I heard somebody mention that that's a little melodramatic. Let me tell you, from my experience last week, that is not a little melodramatic, that is factuality. I beg of you to please look into this.

Dr Geffen: Dr Janet Warren is our next speaker. She's a family physician who practises obstetrics in St Catharines.

1000

Dr Janet Warren: I've been in St Catharines for two years, and I include obstetrics as part of my family practice because I love it. I consider it a privilege to participate in the miracle of birth.

The family practice model emphasizes comprehensive continuing care, and nowhere is this more true than in obstetrical care. Thus I counsel my patient prior to conception, I look after her the whole way through her pregnancy, I deliver her baby, often spending hours in repeated visits at all times of the day, and I provide ongoing continuing care for both mother and baby. Aspects of Bill 26 severely threaten this essential service.

In 1988 the government agreed to provide a rebate for any increase in malpractice after that date. Bill 26 proposes to cancel this agreement. The obstetrical portion of the CMPA or the malpractice insurance fee approximates \$2,500. The OHIP fee schedule for a delivery is about \$250, and this has not changed since 1988, and it does not include the current 18% OHIP reduction. It does not include office expenses, which we have to pay, expenses for continuing medical education to keep us up to date, or other professional fees.

Even with the rebate we are currently receiving, it is apparent that obstetrics is not a financially rewarding service. With this rebate physicians will basically not be paid for the first 10 deliveries in a year, and in fact may even lose money. Many family physicians only do about 10 to 20 deliveries per year. It obviously does not make sense for us to continue.

A few years ago in St Catharines, there were 28 family doctors doing obstetrics. There are now only 12 of us. And with the passage of Bill 26, we will not be able to afford to continue. Who is going to deliver the 500 babies that are usually delivered by family practitioners in St Catharines?

Bill 26 also proposes to limit physician billing numbers. Therefore, new graduates will likely go north or go south. There's already a shortage of family doctors in the area. St Catharines is unlikely to get any new physicians. As has been mentioned, there are now only five obstetricians practising in an area that requires 10. Family doctors rely on these colleagues for assistance with complications. If they are overburdened, we might be forced to practise outside our professional guidelines. Thus, Bill 26 threatens not only accessibility but safety of obstetrical care.

There seems to be an impression that physicians have all the control over the health care system. But we certainly have no control over whether patients get pregnant or not and somehow we are being penalized for this.

Yes, there need to be reductions, but obstetrics is an essential service, not a luxury. True, no one else in society is expected to work for free, but as I mentioned, I do obstetrics because it is personally rewarding. Ultimately, it is the patient who is going to suffer. We cannot afford to compromise obstetrical care in this community.

Dr Geffen: The last speaker will be Dr John Viljoen, who is a practising obstetrician in St Catharines and a gynaecologist.

Dr John Viljoen: Mr Chairman, ladies and gentlemen, thank you very much for this opportunity to address you today on behalf of all the obstetrician-gynaecologists practising in the Niagara region.

I can give you some statistics, more specifically to my own hospital, and I would like to set the scene for you. This is not a whining session. We are five obstetricians

currently practising in St Catharines. You have heard the caseload is roughly in the order of 2,300 deliveries a year. If we add the other six smaller hospitals in the Niagara to that, we will approach 5,000 deliveries per year.

Currently, there are only 12 of us who provide this service in this area. In St Catharines, it's five of us doing approximately 1,500 to 1,600 deliveries per year. The guidelines of our own society state that we should be delivering, on average, 20 to 25 patients per month to be practising at a safe and reasonable level. All of us are exceeding that by far, delivering 35 and more patients per month. Our offices look like disaster areas most of the time. We are practising under enormous stress.

Bill 26 was not the injury; it was the final insult. The injury had come long before. The climate to practise medicine, and particularly obstetrics, has been steadily declining. I've had the privilege of working in this wonderful country for the past six years. I'm a foreign medical graduate. I'm now a very proud Canadian citizen and I am desperately worried when I see the decline in our system in just the mere six years I've been in this country. And I'm seeing it decline further.

As Dr Warren does, I enjoy obstetrics. I chose to do obstetrics when I was 18 years old. I'd already decided that was what I was going to do. At the moment, I am being forced to practise it in a way which I think is unacceptable for myself and unacceptable for my patients. I'm sure I echo the feelings of every one of my colleagues in the room here today with me and every one of those who could not be here and are working today.

Some mention has been made of the CMPA fees. I absolutely feel disgusted that I have to lower myself to speak about money, but this is what it boils down to. Instead of my worrying about my patients and their unborn children, I'm worrying about where the money is going to come from to pay for my office overhead and to give them the infrastructure they deserve. CMPA fees in Canada, since I came here in 1990, have risen from approximately \$11,000 per year at that point to \$23,400 per year now. That is a doubling in five years. Obstetrics is a privilege to practise, but it's also the most dangerous subspecialty in medicine. One out of five practising obstetrics persons in Canada will be sued every year, and that number may rise due to one of the clauses in Bill 26, with contingency fees being allowed to lawyers in cases of medical malpractice. Those fees may just keep rising. It is making it impossible for us to continue practising.

Dr Warren alluded to the fact that the average family physician has to do 10 to 20 deliveries per year to survive. The average gynaecologist will have to do between 100 and 110 deliveries to just cover CMPA premiums. This is not paying the salary of my nurse or my secretary or any other costs that I have. It's terrible to have to talk about money, but those are the realities I have to face every day.

Why don't we have enough obstetricians? This predates Bill 26, unfortunately. Some of you will remember that since July 1, 1993, it has become impossible for even a fellow Canadian who graduated in a province other than Ontario to enter into practice in this province. So we cannot recruit people. It is not as though we are

trying to guard this little cake for ourselves. We would desperately love some help. But we can't recruit people from anywhere but in Ontario. Young graduates are going further south than the peninsula because there is no incentive for them to join us in the peninsula. We cannot recruit people from outside of the country's borders. It's quite enlightening to realize that of the 12 obstetricians practising in the area here, there is only one Ontario graduate. The rest come from outside of the borders of the province, and most from outside of the borders of the country. We have a serious problem.

Previous speakers have also mentioned the fact of confidentiality. As an obstetrician-gynaecologist, I have always regarded my work as being very special and extremely private in its nature. Most of the time it's very difficult for my patients just to come to me, to build up the courage to come to me and discuss some of these issues, let alone ask for or consent to some very sensitive testing. Now they're going to think not only twice, they're going to think 10 times before they ask to be seen, to be listened to and to be tested. I think this is a serious problem.

Furthermore, this bill may allow a bureaucrat with no training—this is not a peer; I don't mind if a peer would do this—can sit down after the fact if I've, as an example, done a hysterectomy on a patient who has been suffering horribly, take her chart, look at the chart and decide, "This hysterectomy was unnecessary. We will take back the money, Doctor, that you were paid for doing this procedure," ignoring my patient's rights, ignoring and underestimating her ability to act as an advocate for herself.

1010

Let me remind you, do not underestimate any of these people in this room. They know how to act as advocates for themselves. This is 1995. Our patients are pretty well informed and there are very few of them who will allow me to do a procedure or recommend a treatment without questioning me very well upon that. That's just been taken away. A bureaucrat can now tell me, "That's unnecessary; I'm not going to pay you for it." I've taken the medical and legal risks. My patient is improved. But I really don't think that's the way a system should be functioning.

Now, I don't want to whine. I would very much like to make some suggestions as to how can we improve it.

First of all, I feel we should all realize that this system is a very precious one. It has users; it has providers. At the moment, as a provider I'm feeling I'm being singled out as the root cause, as the only cause, for the great disaster we are facing, and that's not true. There are users as well. There may be unscrupulous physicians, as there unscrupulous teachers, unscrupulous engineers, and we can carry on down the line.

Ms Lankin: Politicians?

Dr Viljoen: That too, Ms Caplan.

Ms Lankin: Lankin.

Dr Viljoen: Ms Lankin. That is true. But I think our patients should also just be asked, "Won't you also contribute to this mess?" I was not thinking about user fees; I'm just thinking about education. Just educate people as to how does one use a system correctly. That is all we ask.

The next thing is I would really urge the government, please rethink your position on the CMPA rebates. It is making it very difficult for us to continue providing the care we currently are so proud to do. Just to give you an indication of exactly how proud we are of our care in St Catharines, our C-section rate, which is a very contentious figure always in obstetrics, is well below the national average. Our C-section rate, we are proud to say, is between 10% and 11% per year, which I think is pretty remarkable for guys who have been worked to the bone. Our perinatal mortality rate is 2% below the national average. I think that's pretty good. Now we think we are gods, all of us, every day that we practise obstetrics, and I can tell you that's true, to realize our own fallibility. We know how close to danger we always live and we will almost certainly not ride on this wave.

We would love to continue giving that level of care to our community. They deserve that kind of care. In the current atmosphere and in the atmosphere that seems to be coming, that is going to be virtually impossible. We need the support from the community. We need them to become vocal. We need them, just like the patients here, to just give us that little bit of credit to what we are trying our darnedest to do and to stand up and also to speak up for us. We desperately need that. Thank you.

Dr Geffen: That concludes our presentation.

Mrs Janet Ecker (Durham West): Thank you very much for taking the time to come here today and put forward your concerns. Also, Ms Ioannoni, thank you very much for coming and sharing what must be a very painful and difficult memory. I very much appreciate you taking the time to do that.

I think one of the things we've certainly heard at these hearings is that people believe very strongly in their positions. Every patient I know would certainly justify that doctors are one of the highest-paid professions in Canada for a reason and that they're worth every penny. So I certainly can sympathize with people's concern about wanting to make sure they have physicians here.

Mr Wilson, the Health minister, has announced that he is working out a system to make sure that obstetricians are not forced to choose between not delivering babies and paying CMPA fees. I guess one of the things that I find really difficult to understand when you look at CMPA—which, in its last annual report, said there was no crisis, said there was not a significant increase in the number of cases, yet tried to hit us all up for a 20% increase. They were talking about a 30% increase next year. I've got to start wondering why they're trying to rip off front-line docs and the taxpayers here on this thing, without the justification for it.

What I'd like to know from the physicians is, are you aware of anything that your bargaining unit or your representative organization, the OMA, have done to try to address the increases? And secondly, how would you recommend that the government and the OMA deal with the CMPA to try to stop this kind of increase that does not appear, at least from the evidence they presented, to justify the need? Mr Wilson has met or has written to other Health ministers across Canada to say, "Look, can we solve this?" Do you have any suggestions for the minister on how we might get at that?

Dr Geffen: Can we just step back a little and look at the reason and the purpose of this CMPA rebate? I think it was the Peterson government that negotiated with the OMA at the time that the CMPA rebate, this 50% contribution towards physicians' portion of malpractice insurance, would be granted to physicians in lieu of an increase in fees.

Mrs Ecker: I'm well aware of that, yes.

Dr Geffen: So since 1988 physicians have had no increase in fees. By summarily withdrawing this 50% rebate of fees, they have summarily reduced physicians' incomes or reduced the increase in lieu of fees that was given to them in 1988.

I understand the government has great concerns that the CMPA premiums have gone up 20%, you say?

Mrs Ecker: I think it's 30%.

Dr Geffen: One of the reasons given to us by the CMPA is that there is a need to build up a fund for future malpractice claims. What happens at the moment is that a claim against a physician can take place 10, 15 or 20 years after the event. Provision has to be made for funds in the insurance scheme to contend with those claims. With the threat of contingency, I have no doubt that the size and the number of claims is going to increase in the near future. So the CMPA feels that a large surplus is needed to cope with those increased claims.

Mr Bradley: We deal in this bill, and we deal on a daily basis, with the question of the values that Canadians and Ontarians have in our society. One of the highest values that we've had consistently has been that of a very good health care system. We've been prepared to pay for it in years gone by.

Part of the government's program is to borrow \$20 billion, with \$5 billion in interest being charged on that, for the purpose of delivering a 30% tax cut in provincial income taxes for people in this province that would benefit those at the very top end the most. Is it your belief that the government would be better to not cut as deeply into health care services, to provide the funding that you are asking for, that you believe is very legitimate, rather than borrowing \$20 billion more to deliver a tax cut to the people of this province?

Dr Geffen: I can't give you a yes or no. My own personal feeling as a physician is that we are not at this stage asking for more funding for physicians. We understand that cuts have to take place. As responsible taxpayers and responsible citizens, we realize there is a crisis and there is a problem. None of us are whining and asking for more money. What we're asking for is a government that understands our position and is prepared to work with us to try to solve the problem, that listens to our concerns and listens to our input. What you've presented me with is a fact I did not know about and haven't had a chance to think about.

Mr Bradley: The issue comes down to whether you think there should be a tax cut delivered to the people of this province in the present economic circumstances, in a situation where the doctors that you represent and others in our society will not be able to maintain even what you have today in terms of service if the government delivers this tax cut.

Dr Geffen: I'm speaking in my own capacity. My own personal feeling is that I would be quite content not to have a tax cut. I'm prepared to make a sacrifice. I understand that sacrifices are needed from everybody and I'm prepared to make a sacrifice. What I'm looking for is a government that, I must say, many of the physicians put into power—many of us voted for this party—that would listen to us and would be prepared to negotiate with us and not impose upon us a bill that vests so much power in the Health minister.

1020

Ms Lankin: I'll be sharing my time with Mr Kormos, but I just want to say, following up on Mr Bradley's point, that as a result of this 30% tax cut that this government is ideologically committed to giving to people and that's going to benefit the wealthiest people in this province the most, we are seeing greater cuts being made to needed health and social services and community services, and, by and large, the burden of paying for that tax cut is falling on the backs of many people who are very vulnerable in our society. I applaud your personal position with respect to that. I believe that many people in this province are prepared to give up that tax break in order to preserve the needed services and the needed infrastructure and support for people in our community.

With respect to the issue you've raised around the malpractice insurance rebates that the government has contributed to, in the practice of obstetrics in particular, I want you to know that we have heard across this province that many doctors who are currently obstetricians will stop that practice and/or leave the country to practise someplace else as a result of this. We have heard from new graduates that they will not practise in Ontario as a result of this, and we have heard from students making their way through medical school that they will not pick up the specialty of obstetrics.

The minister has made some vague promise that he will work to fix this in your area. We haven't seen the amendment; we don't know what it's going to be. We hope that in fact the minister does that, but I need to tell you that orthopaedic surgeons are facing exactly the same issue. So are neurosurgeons. To me, it underscores the fact that this government moved ahead with a set of amendments, an agenda that—I don't know where it came from, because it wasn't in the Common Sense Revolution. They didn't consult with anybody. And now in a couple of short weeks we're trying to fix all of these problems.

Were you consulted with and/or do you think that we need to take a bit more time to understand some of the unintended implications of this government's actions?

Dr Geffen: My answer is I had no knowledge—I don't think we were consulted, and if we were, I don't think any of our opinions were listened to. I don't think the OMA input was considered.

Ms Lankin: Just very quickly, are you aware of the problem with respect to orthopaedic surgeons and neurosurgery, and do you agree that those are specialties that also will be affected by this?

Dr Geffen: Yes, I do.

Mr Kormos: People, please, you've got to understand that this government didn't even want to include the

public to the extent that it has. It took Alvin Curling, a member of the opposition party, to risk uric poisoning by sitting in the Legislature overnight to force the government to have these two weeks of modest travelling hearings. We've got 17 schedules in this bill; that's effectively 17 different pieces of legislation, all of them with a profound impact.

It was developed in secrecy. Government backbenchers weren't even aware of the legislation until after it had been tabled as a bill in the Legislature on first reading. They were coming to members of the opposition, asking us for copies of the bill. Not only hadn't there been any consultation with the public prior to this legislation being written; there hadn't been any consultation with the government's own caucus. In fact, now that they discover error after error, they're scrambling in retreat to try to clean up messes they created with their haste.

Of course, you've been described as Ontario's highest-paid profession. See, that's part of the imagery that this government relies upon. They want to paint doctors, small-town Ontario doctors like you and a whole lot of folks in Welland-Thorold and across the region, as being the Mercedes-Benz, Caribbean crowd, while the fact is that the pay envelope for Frank Stronach of Magna last year was \$47 million. The government's telling you to take a hit, but they're not telling Frank Stronach to take a hit, based on a \$47-million pay envelope.

The Chair: Thank you, folks. We appreciate your attendance here today and your interest in our process.

Our next presenter is the Merck Frosst company. The Chair, out of necessity, has to take a three-minute recess.

The committee recessed from 1024 to 1027.

MERCK FROSST

The Chair: If we could have the members back at the table, we can continue, please.

Representing the Merck Frosst company, we have Bob Stinson, Brian McLeod and Greg Szabo. Welcome, gentlemen. You have a half-hour of our time.

Mr Brian McLeod: Mr Chairman and members of the committee, I'd like to thank you for the opportunity to appear before you today. My name is Brian McLeod. I am vice-president of marketing for Merck Frosst. Joining me this morning are Bob Stinson, manager of government affairs for the province of Ontario, and Mr Greg Szabo, manager of drug plan affairs for the province of Ontario.

I would begin today with a brief background on Merck Frosst, followed by some very specific comments and recommendations on the proposed legislation and changes to the Ontario Drug Benefit Act and the Prescription Drug Cost Regulation Act contained in Bill 26.

Merck Frosst is Canada's largest integrated pharmaceutical company. The prevention and treatment of disease is the mission, heritage and business of our company. We spend more on research and development, including basic research and clinical development, than any other Canadian pharmaceutical company. Indeed, our investments in research and development place us among the top 10 R&D corporations in Canada in all industries.

In 1995, we invested close to \$52 million in research and development, approximately 14% of our total

national sales. We have 1,100 employees across Canada involved in the discovery, manufacture and marketing of medicines and vaccines for human and animal health. Our manufacturing division produces over 150 prescription and over-the-counter medicines for Canada and international markets. Here in Ontario, we operate a regional business and distribution office in Mississauga. We have 123 employees based in the province, and last year spent \$56 million on goods and services in the province.

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The money we spend on R&D had a direct impact beyond our company. Currently, 35 hospitals in Ontario and nine universities receive research and development support from Merck Frosst. This creates direct jobs within those research facilities as well as additional indirect jobs for suppliers and support companies. Our research effort is part of a worldwide mandate of Merck and company aimed at treating patients with a wide range of conditions, including cardiovascular disease, osteoporosis, AIDS, asthma and prostatic disease.

Further, we are taking the lead in developing integrated patient health care programs, what we call patient health management, to improve the delivery of patient health outcomes and bring cost savings to the health care system. To this end, we are currently funding a three-year program at the University of Western Ontario and Victoria Hospital in London. This program is custom designed for the patients, physicians, pharmacists and other health care professionals who are involved in a coordinated manner to strive for implementation of best medical practices in the area of cardiovascular medicine. The end goal of this project is to improve patient outcomes and reduce overall costs.

Before offering our specific comments on Bill 26, I want to take a moment to express our views on how drug benefit programs should operate, together with their contribution to the health of Ontarians and the growth and development of the province's pharmaceutical industry.

At all times, the overriding focus must be the patient's health. Each of us, as health care providers, bear a particular responsibility to make this end goal a reality. In doing so, we believe there are several goals the drug benefit program must achieve.

The first goal of the drug benefit program should be to provide equitable access to prescription medications at a fair and reasonable cost to both beneficiaries and to the taxpayers who fund the program.

The second goal should be to ensure that Ontarians receive access to the newest and most cost-effective drug technologies in as timely a fashion as possible to ensure optimal care, defined as being the best care at the lowest cost.

The third goal should be to ensure that the drug benefit program is managed efficiently to achieve all possible savings for consumers and taxpayers. This in good measure can be accomplished by ensuring that drug reimbursement prices, drug listings and usage guidelines are open and transparent to all affected parties.

I'd now like to turn to the proposed legislation and offer our comments in four areas: first, reimbursement determination and listing decisions; secondly, drug interchangeability; thirdly, treatment guidelines and reimburse-

ment; and lastly, consultation and the regulatory process. I would comment that we have also provided, in addition to this, a detailed analysis of our specific recommendations and it's provided to you under separate cover.

Turning first to drug reimbursement and listing decisions, Merck Frosst supports the government's proposed amendments to the newly named Drug Interchangeability and Dispensing Fee Act to eliminate best available price, BAP, and move to a more deregulated environment. This will serve two purposes: first, to eliminate a level of duplication with pricing authority of the Patented Medicine Prices Review Board, commonly referred to as the PMPRB; and second, to encourage price reduction in the non-regulated ODB pharmaceutical sector through greater competition.

The PMPRB is already an effective regulator, not just of introductory prices for new medicines, but of price increases for established medicines which limit annual increases to the level of the consumer price index. Under the PMPRB, Canada cannot have the highest price for a new or existing drug within the seven international drug markets compared by the board. Since the PMPRB came into creation in 1987, patented drug prices have increased by an average of only 2.1% per annum, compared to a CPI over the same period of 3.3%, as noted in a speech by Minister Wilson. In short, effective controls on patented drug prices already exist.

We believe that the elimination of the BAP, or best available price, will not result in excessive or discriminatory prices for patented medicines in the non-ODB sector because there is no mechanism in place for us to differentiate the price of our product charged to an ODB customer versus a non-ODB customer at the pharmacy level. We establish our ex-factory prices taking into consideration cost-effectiveness, the competitive environment and the PMPRB guidelines. As part of our pricing practices, we adhere to a one-price policy for all of our products to all customer types.

Additionally, we are of the opinion that sufficient competitive mechanisms exist in the Ontario marketplace today to mitigate against price increases and quite possibly lead to decreases in prices in both the non-ODB and the ODB segments.

On the related topic of reimbursement prices, Merck Frosst is of the opinion that the reimbursement price for listed drugs with a valid patent should be equal to the current best market price which also reflects available discounts and rebates offered to the non-ODB segment of the market. Therefore, the negotiations between the government and the manufacturer referred to in the proposed legislation should be limited to identifying and agreeing to discounts and rebates which exist in the marketplace.

We would recommend that government not arbitrarily set the reimbursement level lower than the current best price as described above. To do so would mean the difference would be borne by the patient. We would submit that this is a punitive form of copayment in that it is not based on the ability to pay.

With respect to drug listing decisions, the criteria in the legislation are not yet established in regulations. We look forward to receiving additional details on the

implementation of this process. It is our view that the government now has an opportunity to take a more comprehensive and integrated approach to drug listing.

Price is one factor. Value is another. Many medicines save the health care system money in other areas through reduced hospital stays and fewer medical interventions. It is our obligation as manufacturers to prove the value of our products by demonstrating improved health outcomes through the conduct of drug cost-effectiveness studies. We believe in turn that the government should factor this value into its listing decisions. Cost-effectiveness studies permit the scientific evaluation of the effect a new drug will have on broad health care costs, such as hospital costs and other medical interventions. As such, they are a management tool available to government and industry to work together and find solutions to rising health care costs. Simply put, if cost-effectiveness studies indicate a drug offers value to the overall health care system, it should qualify for approval.

As I mentioned in my introduction, Merck Frosst is pioneering patient health management programs in Canada which employ proven, best medical practices, patient education, drug and non-drug treatment compliance programs and other measures to deliver better patient health outcomes, lower total cost and improved patient satisfaction.

We would recommend that the government lend its support and endorsement for patient health management programs as a means of improving the health of the citizens of Ontario and of effectively managing health care expenditures.

A final factor in product listing that should be considered by the government is patent status. Generic drugs have an important role in cost reduction once the patent for the drug they are copying has expired. Questions about patent status and intellectual property rights should be resolved in advance of a generic coming to market. Listing a product on a formulary with unresolved legal issues violates these principles. We believe the government should establish criteria that respect intellectual property rights and prevent patent infringement by allowing a generic to be marketed with outstanding patent claims against it.

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Turning now to treatment guidelines and reimbursement, Bill 26 proposes to restrict drug reimbursement under the ODB act to specified prescribing criteria or clinical guidelines that will govern whether a prescribed drug receives reimbursement from the ODB program. We support well-founded treatment guidelines that promote medical practices consistent with current scientific evidence of efficacy and cost-effectiveness in obtaining optimal patient outcomes.

Merck Frosst is of the opinion that implementation of treatment guidelines as an educational measure is the most appropriate route to follow. Therefore, we are opposed to the linkage of reimbursement to treatment guidelines. Physicians are in the best position to judge the most appropriate treatment for the patient, and we believe that reimbursement systems must allow for physician judgement in the appropriate treatment of each patient as a unique individual.

In sum, well-founded, evidence-based treatment guidelines can be helpful in improving patient outcomes. They have a useful role in promoting best medical practices and Merck Frosst supports their development and use in this manner. We recommend that the government support patient health management programs in which guidelines are used to educate and encourage the best practice of medicine.

Turning for the moment to the issue of drug interchangeability, for many years now the ODB program, as well as other provincial drug benefit programs, have imposed drug interchangeability between generic and brand names as a means of keeping costs down. Mandatory substitution rules in Ontario legislation are the mechanism used to achieve this goal.

It is important that interchangeability allow for only interchangeability between different manufacturers' copy of identical molecules. Drugs composed of different molecules, even within the same therapeutic class, are not the same drug. Their interchangeability for either therapeutic or pricing purposes is not possible.

We raise the issue because proposed amendments contained in schedule G would allow the government to determine the drug benefit price based on a comparison of the price of "other drug product" in section 22 or a "class of drug product," which leads us to express the following concern.

Interchangeability of different molecules increases the probability of degradation of patient health outcomes. Not every drug in one therapeutic class acts in exactly the same fashion, providing the same health outcome. This could potentially be more pronounced in a patient taking drug therapy for a chronic condition, such as heart disease.

We therefore recommend that the term "interchangeable" within the legislation be simply and unambiguously defined to apply to only an identical molecule in the same dosage format.

Turning to the last section, on consultation and the regulatory process, we have certain questions based upon eventual regulations and criteria not yet published that will give effect to the proposed changes contained in Bill 26. We welcome this opportunity to present our concerns to the committee and offer suggestions for improvement and clarification.

The legislation changes proposed will create a new business environment for our industry. We believe that it would be reasonable, because of our expertise, that we be given a full opportunity to work with government through a formal consultation process and review supporting regulations and criteria. This is particularly important in the areas of reimbursement determination and listing criteria, drug submission requirements and clinical practice guidelines.

The need for the government to take immediate steps to get the province's finances under control has led us to this stage. We understand this. The next step is to create a more open and transparent regulatory process, both to ensure legitimate input is received and prevent future problems from arising. We hope this committee will recommend such process in its final report.

The regulatory process is equally important in determining new product listings on the formulary. We support the minister's recent commitment to streamline the drug approval process. This should take the form of reduced red tape by lessening redundant information requirements for each submission, more transparency behind each listing decision, regular status reports to companies on where their drugs stand in the approval process, and greater certainty in eventual results. The results should be a greater number of cost-effective new products listed in a more timely fashion to the benefit of all Ontarians.

Let me close by thanking each of you for the opportunity to appear before you today. The changes proposed by the government to Ontario's drug legislation are significant and require your careful consideration. We believe that our recommendations will provide Ontarians with improved health and pharmaceutical care, improve the management of the drug program and assure continuing investment by the research-based pharmaceutical industry into this province's future.

I refer you to the detailed list of specific recommendations and now would be pleased, along with my colleagues, to answer any questions you might have.

Mrs Sandra Pupatello (Windsor-Sandwich): I'm assuming from what I'm reading that perhaps you have been consulted by the Minister of Health at some point over the last six months.

Mr McLeod: I guess that depends on how you define "consulted."

Mrs Pupatello: Have you had meetings, have you met with him, spoken with him, your company?

Mr McLeod: I think it's important to understand, as a pharmaceutical industry, we're a highly regulated industry. Government is an exceptionally important partner in the delivery of pharmaceutical care. So there it would not surprise you to know that we've worked with the present government, past governments—

Mrs Pupatello: I just wanted to confirm that indeed you had been consulted. There were so many other partners in health care that were not. It was good that a major pharmaceutical company was.

In London, London Life spoke with us as a business. You have 123 employees; do they have a health benefit package including a drug package?

Mr McLeod: Yes.

Mrs Pupatello: These people from London Life felt that in fact employers will end up picking up the cost of increased drug prices. How do you feel about that?

Mr McLeod: Going back to what I was saying earlier, it would be our opinion, as I've stated before, that for patented medicines there's already a system in place and it's highly unlikely and would not be for our products that there would be price increases.

Ms Lankin: Mr McLeod, with only two minutes, I'm going to make some observations and not ask a question because I appreciate your presentation. It's very clear in terms of your company's position on certain aspects of the changes to the drug legislation.

I note there are other aspects that you haven't commented on, even with respect to the drug legislation, like the structure, the copayments and whether or not that

deals with utilization versus some of the other very good suggestions you've made about prescribing guidelines and how they should work in terms of peer education.

My big problem with this, besides the fact that it's buried in a whole huge bill and we're trying to deal with so many aspects of change to public life in Ontario, is that I don't believe the government really knows yet what the impact of some of these changes will be.

I appreciate that you believe that deregulation of drug prices in the open market, outside of the Ontario drug benefit program, will lead to competition and will lead to lower prices. I put to you that the generic drug industry came before us and said they didn't know that that was the case, and had some differences of opinion with the brand-name companies, which is not unusual but at least the committee received differing advice.

London Life suggested that at least in the next three to five years, the prices would go up until people gained new tools to be able to manage this kind of open competitive market. Rx Plus, which is drug benefit program management company, said that they thought it would go down. We don't know and we went back and took a look 10, 15 years ago when the drug legislation came in and what was going on there, and you had people from the Niagara region and Hamilton driving all the way to Honest Ed's in downtown Toronto to be able to get the best price on drugs, and the minister has suggested that the consumers will drive a competitive market because they'll shop around. I'm concerned about that.

One member of the government committee said: "Well, this has got to be good because deregulation is good. Look at the airlines." To me, necessary medication for people who are ill is not like deregulation of airlines.

The Chair: Unfortunately, Ms Lankin, there's no time for an answer.

Ms Lankin: I didn't want an answer; I said I wanted to make some observations.

The Chair: Okay, I'm sorry. Mrs Johns.

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Mrs Helen Johns (Huron): Thank you very much for your presentation. As Ms Lankin has said, we have had a number of groups come in and talk to us about drugs.

I understood from the question Mrs Pupatello asked you that the price of patent drugs would stay the same. What has setting the price or the ceiling for generic products done to the price of generics, in your opinion? I know this will be in your opinion; I just want to hear what would happen in different classes of drugs.

Mr McLeod: If I understand the question, it's: What has the current legislation done in terms of generic prices?

I think what has happened is that it has led to a situation where generic prices, although lower than the name-brand prices, are relatively close to our prices, and they have not moved down all that low all that quickly. I guess that's what I would say. By opening up a competitive marketplace, there might be potential—it's difficult to know—but it might create more competition and there might be opportunities within that particular segment. Does that answer your question?

Mrs Johns: Yes. Thank you.

The Chair: Thank you, gentlemen. We appreciate your presentation this morning.

LIBERTY HEALTH

The Chair: The next presenter is Liberty Health; Bill Wilkerson, president, and Gerry Byrne.

Mr Kormos: On a point of order, Mr Chair: There's a whole lot of nurses in this room. Perhaps they could stand up—the members of the nursing profession—and let us know that they're here. They called making inquiries to participate in this hearing, and were told that they didn't have a snowball's chance in hell of getting on to the list of presenters. Why doesn't this government want to hear from nurses in Niagara region who are the front-line service providers?

The Chair: Thank you very much, gentlemen. Welcome to our committee. You have roughly a half-hour to use of our time. Questions, should you allow the opportunity for them, would begin with the New Democrats. The floor is yours.

Mr Bill Wilkerson: My name is Bill Wilkerson. I'm the president of Liberty Health. On my left is Gerry Byrne, the senior vice-president of the company. Gerry will participate both in the presentation as we go, as occasions allow, and in the question area; as will Tom Boa on my right, who manages Liberty Health's businesses in the south and western part of the province, including this particular community.

We appreciate the opportunity, obviously, of being given a chance to express ourselves today. Liberty Health is the former Ontario Blue Cross. It is the province's largest supplementary health benefits management company, and our coverage includes more than two million individuals, both in terms of reaching them through their group plans as employees as well as direct to them as individuals themselves.

On a daily basis, Liberty Health deals with 200 hospitals, 2,400 pharmacies, 2,500 dentists, and various other providers in all regions of the province, often through electronic claims processing, giving us knowledge of benefit issues across the province we think in a unique enough way. It also gives us a perspective on the utilization issue which, bearing in mind the implications of this bill, is now a very real issue in Ontario drug management areas.

I'd like to make two kind of personal qualifiers before we begin the substance of our presentation. One is that Liberty Health is here today as a voice, if you will, not of the industry represented by insurers; we are not an insurance voice at these proceedings. At the same time, we want to underline, I guess, that what we are offering you is a combination of our analysis of the implications of Bill 26, particularly as it relates to the drug plan, and also that we are reflecting the voice of our customers, those being employers, public sector employers who constitute more than half of our customer base, employers who represent larger and smaller groups of people. In this community alone, Liberty Health represents the regional municipality and has a very real and immediate concern for the implications of this legislation on the public sector employer and public sector employees.

Supplementary health, I might just add another point parenthetically, by way of a position in the health care spectrum today represents about \$1 in every \$3 expended

on health care in Canada and represents to us not a growing area in terms of replacing primary care or core service in health care delivery, but in fact a support sector which is growing by way of the need of the individual.

Our customers represent, and thus the voice we hope you will hear today, people living in both urban and rural communities, job entrants, pensioners, large manufacturers, entrepreneurial firms, municipalities, universities, school boards, hospitals and the agencies and institutions which represent the backbone of the Ontario public sector. In fact, one person in five, just about, in Ontario receives Liberty Health coverage in some form.

We're here, therefore, not as petitioners for a particular point of view corporately but as a vehicle through which to express some of the concerns and feelings reflected to us from this range of Ontario life.

In doing that, I think we need to underline, as should anyone who is going to present a view on this bill, it seems to me, that there is an inevitability that government must reduce expenditure, government must deal with deficit. The challenge posed, however, by deficit reduction—deficit reduction born of a decade or more of building a culture of debt in this province and across this country—is that deficit reduction must be connected in the broader context of human need and the impact in very particular human individual terms. This legislation, as it relates to the drug plan, must be considered in that light. We urge you, whether it's substantively related to the provisions of this bill or dealing with the aftermath of it, to give expression to the need for people to understand how this affects them and not just organizations and not just large corporations such as ours have the opportunity to prepare to be here with you.

There will be human implications and there will be a human impact as a consequence of the changes proposed in Bill 26 as it pertains to the drug plan amendment. We would like to characterize that impact to you as a community cost. In this sense, the changes set out in Bill 26 become not a matter of cost reduction only—yes, in government terms, it comes off the books of the government of Ontario—but represent in very particular ways a cost transfer from government into the wider community. The people in this room are the people who are going to pay for it not only as taxpayers but in other forms—as employees, as representatives, as family leaders. That may not necessarily be the wrong thing ultimately, but we urge you to consider that it is a cost transfer, not a cost reduction, when you see it in the broader community light. If 225 million bucks that come off the government books go on the people's backs, I think the fact of that may well be that this bill needs time.

The shift in costs is accompanied by a shift in accountability and responsibility for drug usage and benefit management. The shift to seniors, to unions, to business, of course, as employers, the public sector as employers, municipal governments as employers, universities as employers is a community cost that we submit to you had not yet been assessed with respect to the point of whether or not the full implications of this legislation are known. We submit to you that this cost impact has not been suitably assessed as yet.

The cost transfer does something else. It shifts a new level of direct cost on to the employer base, both public and privately owned organizations, we submit to you, without suitable notice. This at a time when that cost base in competitive terms or in service terms, when you relate to the public sector employee, is already overloaded, given the environment we're living in and the society we're living in today. That the cost transfer happens may not be the wrong thing, but that it is happening in an unforecast, unheralded manner could make it unmanageable when it lands with full impact in the community.

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In one example, one large employer we serve faces an estimated \$2-million annual liability that was not planned yesterday. On a compounded basis, that can have a major effect for the employee and for the consumer that organization serves.

In another, a university in Ontario faces a new half-million-dollar cost in annual benefits at a time when transfer payments to that institution are being restricted at the other end.

For public sector employees the implementation of these changes is critically timed, obviously. For employers in this sector, currently covering pensioners over age 65, for example, increased liabilities will coincide with a significant decrease in transfer payments.

For the people of Ontario generally over 65 not covered by third-party drug plans, and whose incomes exceed the proposed levels of \$16,000 and \$24,000 a year, not a very high level in terms of the base, access to drugs could be limited by the installation of the copayments.

Limiting access in this way could also result in cost increases in other areas of the health care sector. One must accept the inevitability of spending cuts. No one argues with that, I don't think—perhaps in principle, but not in commonsensical terms.

Certain customers of our business, both the public and private sector employer, have suggested that a period of transition and adjustment is needed to accommodate the changes contemplated by this legislation, and we believe the recommendation which we are conveying to you on their behalf here today is a reasonable one.

We also recommend that the government delay the implementation of \$100 deductible and dispensing fee copayment, or alternatively increase the proposed income level ceilings of \$16,000 and \$24,000 a year. Those are not very high levels of earning in today's world.

Our customers also question whether changes to the ODB plan may ultimately put the concept of early retirement at risk in this province. We ask you to reflect on that. That could be a profound question, not only in terms of that issue as a means by which organizations have more compassionately downsized in the face of rushing necessity, but individuals changing, preferring a change in their life, may find that change at an earlier age rather than later no longer within their grasp.

One little analysis we have done so far suggests that particularly for the larger employers this bill opens the door to cost increases for early retirement purposes being multiplied anywhere from one to five times the current. The note I have here from one of our senior executives says, "Add to that the impact of accounting requirement

changes unrelated to this bill, and the capitalization of this very progressive concept of drug benefit as a guarantee is jeopardized."

I think the issue of what drug benefits are as part of an overall benefit program is worth reflecting on. We used to hear the term "fringe benefits" in the labour negotiations or in other terms. Fringes are no longer what we view benefits to be. We see them as guarantees and they are centre stage in employees' minds and we, philosophically as well as operationally, think that is a correct perception. Suddenly now employers, though, have an unclear picture of long-term liabilities in drug and other benefit areas and will be forced to re-examine long-term obligations in providing benefits which facilitate early retirement and other forms of pensioner security.

Benefits, by extrapolating this concern, not in an exaggerated sense, I would think—and Mr Byrne, who's been analysing these matters for a long time, has had many years with Ontario Blue Cross and now Liberty Health, will tell you when we discuss the point, I think, that we are perhaps nearing an era when benefits could emerge as a take-away, or not a guarantee, because of the compounding effect of the cost transfer taking place here.

We believe the proposed deregulation of pharmacy pricing may well lead to increased costs being passed on to the consumers and the employers. Particularly vulnerable are those employers and employees in the municipalities, universities and public sector generally who face the pressure we mentioned earlier. To meet these budget targets, in fact, employers will begin capping their contribution levels to benefit plans, and this is going to increase the accountability of the employee.

I might just add a point parenthetically and then we will finish in about two minutes on this formal side.

We hear about cost increases presumably driving price increases. I would have urged this committee to acknowledge that consumers, not companies, drive prices down. Companies don't bring down prices as an act of charitable goodwill; companies bring down prices in order to remain competitive and to service and deliver business, as will we, going forward. We are a business and we will bring prices down in order to meet consumer needs.

That being the case, we think coming out of this bill, aside from the substance of it, there must be in this province a real era of consumer information and consumer education to help the consumer walk up and down the street, so to speak, making informed choice. Liberty Health will offer itself, with a tradition of public service as well as a real, live business objective, as a catalyst for that. Under Mr Byrne's leadership, in fact, we'll be launching a very aggressive heavier, rather than less, investment in capital for information technology to help facilitate an incremental growth in consumer information and consumer knowledge about what is available to them in the form of prescription drugs. Consumer information will bring price down, not corporate thinking.

I also ask you one other issue. It's kind of ironic, in Ontario's historic desire to distribute more fairly physicians in this province, that this legislation on the drug side has the portending risk of making it less attractive for pharmacists to live in non-urban areas. In this respect, we ask you to listen to the voices from northern Ontario

with great intent. We at Liberty Health have a fundamental interest in the wellbeing of Sudbury alone, through their major employer and that municipality. We ask you to listen to their voice as to the implications of this legislation.

That being the case, we recommend to you, and to the government, that regulation of drug prices continue through 1997. The government should continue to enforce the protections now offered through the Prescription Drug Cost Regulation Act through next year.

We've got to understand one other point, as it goes to questions of price and cost and consumer effect and employee effect and human impact: that on average the drug component portion of a prescription represents 72% of the cost. This government perhaps, in policy terms and in directional terms, is on the right track with deregulation. But you are pulling the plug on protection of the consumer for 72% of the drug price, which relates to the manufacturing aspect of that cost—72%. We ask and wonder whether that is known.

In the face of change of this magnitude, consumer information, as we mentioned, becomes crucial. We will work with health agencies, pharmaceutical manufacturers, employers and other groups to increase consumer information and awareness in order to enhance consumer choice. We feel very strongly that employees, as members of group plans, should be seen and treated and respected as consumers and not as people who have no voice in this. In fact, they must have a voice as consumers, through their representatives and as employees directly.

Final point: We are going to encourage our customers, two million in Ontario—and Liberty Health is committed to expanding beyond this province—to access drug dispensing by mail order or through hospital-owned pharmacies as a means to consumer choice and cost containment.

We'll work with employers and unions to deliver maximum levels of benefits at the most reasonable cost. Prices must come down, not go up.

We will initiate pricing rebates or added-value negotiations with drug manufacturers, based on volume purchases. Prices must go down, not go up, in our view.

We must coordinate on the basis of benefit guidelines in order to universally apply them, to ensure risk and responsibility are allocated appropriately.

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A hard-case example of that is, when a husband-and-wife team is insured, for group purposes or dental benefit purposes, by two different employers, then that risk has got to be divided between those two employers. The duplication—the phrase being “duplicate coverage”—is an undiagnosed ill in the system in this province.

Through network use we will urge that the dispensing of medications be reviewed annually to ensure quality. The 1980s taught us that business can overextend. The 1980s taught us something else: that when you've got to restructure and bring price down, quality's got to go up. Those things are not anathema, and it seems to us that they must be a fundamental pivot upon which this legislation is introduced.

We believe our customers, employees and employers both, have a non-institutional and very particular interest in this and we hope to reflect that view here today.

With that, Mr Chair, I appreciate the time for the statement, and we would like very much to take questions or engage in dialogue.

Ms Lankin: Let me just continue on the comments that I was making to the last presenters. I think you've underscored it. If I understand your presentation, in two or three different areas you're saying: “Let's not proceed immediately. Delay the implementation of aspects of the copayments and the dispensing fee and the deductible, because we don't know exactly what the impact's going to be, first of all on individuals and the cost factor, and secondly, with respect to shifting that cost out into the private sector.”

I think that's an argument that could be made throughout this bill. There are going to be higher costs to benefit packages outside of medicare. That either means fewer people are going to get those benefit packages or they're going to be scaled back, or there are going to be greater costs in the system. We know right now that health care costs to employers in our province are one of the big competitive edges they have. In the auto industry, for example, in the States it costs \$4,000 per year, per employee to fund their health care insurance programs; in Canada it's \$700 per year, per employee—a big issue.

You've said, “Slow down in terms of the copayment.” You've said: “Don't deregulate the prices. We think there are problems there.” We've heard both sides argued.

Mr Wilkerson: Through 1997.

Ms Lankin: My bottom line, I think, is that this is not a well-considered schedule in this whole bill. There are a lot of questions that could be answered by the kind of process that you've suggested putting together at the end of your presentation.

Would you support a recommendation to the government that said: “Look, we know there are issues you want to deal with here. You're going a little too fast. Could we take this schedule out of Bill 26 and spend another couple of months looking at the implications of it and working out some of these problems, and bring it back in the spring session and deal with it then?” Would that be a rational way to proceed?

Mr Wilkerson: We would endorse that. We would also endorse the view that Liberty Health—and I'd like Mr Byrne to comment further on this very point—would offer itself and our good offices as both a public-interest company as well as a commercial-interest company to help facilitate that process. We're going to do it anyway on our own. If this bill is law we have an obligation, we feel, to help sort out the implications.

I want to underline one thing particularly. This is not a criticism of the government's intent or attempt to bring order where order is needed or to bring costs down in terms of the tax base of the province. It is a question of timing and a question of understanding implications of things; it's a question of placing these changes into the context of the human effect they are going to cause. That isn't philosophical or partisan. That is a basic, fundamental business and community issue.

Mr Clement: With respect to the human effect, I agree with you. When government acts or refuses to act, there is a human cost to that. We felt, on balance, that refusing to act would create greater misery than that which you have spoken about.

I wanted to flesh that out, because with the money saved from copayments and accountability in the system, we have been able to announce at the same time an extension of the Trillium drug program to 140,000 of the working poor who had no drug plan protection in the past. The money is being reinvested, in a sense, in that program. Are those the kinds of actions that you're looking for from a government?

Mr Wilkerson: Yes. We acknowledge the wisdom and the positiveness of the Trillium program. Gerry, would you care to comment more particularly about the copayment issue?

Mr Gerry Byrne: Absolutely. We do not at all disagree with extending it to the working poor and to a greater degree under Trillium. What we have in fact understated here is that this is a cost transfer to an employer base and a consumer base that has an inability to absorb or an inability to pay. Many are tied up in negotiated agreements through some time and are picking up, as Bill mentioned earlier, a cost that was not anticipated. The reality is that in human terms, in many cases the only offset will be perhaps additional layoffs, which is totally against what we are trying to do. It's basically a timing issue.

Mrs Papatello: I first want to say that you've put together succinctly, better than many—your presentation was excellent. You represent big business and small business; you represent business. It's very surprising to hear how strongly you feel about the process of the bill, about the fact that parts have to be separated and that we have to delve further because in theory things look wonderful, but practically they can be an absolute disaster. It begs the question about who the government consulted and to what degree when this was put together. Mr Byrne, could you continue your remarks to help us convince government members today that the bill must be split apart and that additional comment and time for hearings in this process are critical.

Mr Byrne: I'll even extend your definition of "corporate" and "business." As Mr Wilkerson mentioned earlier, we are representing our customers, and we did seek their input. We've had meetings with them. That includes individuals; I personally met with 60 pensioners in Belleville. We have gone out on our own and got the voice of our customer. The issue here is time, transition. Philosophically, I would say the consumers themselves do not argue with the issue, the fact that we must change. But it is a timing issue and a way to adapt, both transitionally within the companies and also within the behaviour of the consumer.

The Chair: Thank you, gentlemen. We appreciate your presentation here this afternoon.

We're going to skip now to the 11:30 group, the Lincoln County Academy of Medicine in the Niagara Peninsula, Dr Arthur Shimizu.

Mrs Caplan: While they're coming, can I put a question on the table, as has been our practice?

The Chair: Yes.

Mrs Caplan: We received this morning answers to questions that had been asked in Ottawa from the Royal Ottawa Health Care Group regarding protections of the Mental Health Act, confidentiality. It's not clear to me in the answer to the question, and I'd like further clarification from the ministry.

Do the provisions of the Mental Health Act override the concerns that have been raised, effectively override Bill 26? Also, as the Mental Health Act applies to inpatients, why is special protection for mental health patients or anyone seeking psychiatric services given only to those on an inpatient basis? What's the rationale for having different confidentiality protection for people who are in hospital when we're seeing a shift to community, to outpatient, and drug therapies are allowing people to be deinstitutionalized? Is the government aware of that disparity as the legislation stands?

Second, in view of the number of nurses here—we have not heard from nurses; we have heard from many associations of doctors, many associations of hospital administrators and hospitals and so forth—I'm asking if this committee would allow the nurses at this time to take the available slot, and I do so move.

The Chair: How much time?

Mrs Caplan: Half an hour, a regular presentation. I understand that space is available.

Mr Clement: Yes, that's fine.

The Chair: Do the nurses have a presentation?

Mrs Caplan: If they're ready, or we could hear another one and then they could go on at 11:30.

Mr Kormos: That's the problem, Chair. That's why the motion earlier today is the way to have addressed that.

1120

Mr Bradley: A quick point of order, Mr Chair: If the government members agree, if all members agree, perhaps the solution might be to have Dr Shimizu make his presentation now and the nurses immediately after.

Mrs Caplan: Can we do that? That will give you half an hour to get your presentation here. Good.

The Chair: Is Dr Shimizu here, from the Lincoln County Academy of Medicine?

Interjection: Mr Chair, he's not yet here, but Dr McMain, who is also part of the presentation, is here.

Ms Lankin: Mr Chair, I want to add a question to be tabled. I received answers to my questions with respect to the cardiac surgery network—totally unsatisfactory answers. They did not answer the questions I tabled.

Second, the series of questions I tabled with respect to independent health facilities, the ability of American for-profit companies to come in and start to take over delivery of health care services through that sector, also have not been fully answered. I specifically asked for a list of the American companies, or the Canadian subsidiaries of American companies, that the Minister of Health had met and consulted with, and there is not one reference in the answer to that question in the material I received. I place that question again and I ask for that, otherwise I will proceed with a freedom of information request.

Mr Clement: We had a mixup in terms of the distribution. I gave them all in.

Mrs Caplan: You are trying my patience.

Mrs Ecker: I don't have it either, Elinor.

The Chair: Are we going to listen to these presenters or are we going to argue among ourselves?

Mr Kormos: Mr Chair, I have three questions, please. First, why do the Tories persistently refer to the new costs as copayments when they are in fact the user fees that Mike Harris promised wouldn't be imposed upon consumers in Ontario? Second, why did Mike Harris lie to the voters of Ontario about imposing user fees? Third, understanding that the Administrators Coordinating Committee for Niagara Region Hospitals is not here today—it's not any secret that they're purposely not here—what did the government cave in on with respect to the Ontario Hospital Association such that the local Administrators Coordinating Committee for Niagara Region Hospitals feel no need to appear today? Obviously, they got greased, they got pieced off. What about doctors and nurses and consumers and sick people? How come they're not being accommodated in the same way?

LINCOLN COUNTY ACADEMY OF MEDICINE

The Chair: The next presenter is the Lincoln County Academy of Medicine. Welcome, gentlemen, to our committee.

Dr Art Shimizu: My name is Art Shimizu. On behalf of the Lincoln County Academy of Medicine, we would like to thank you for inviting us to make this presentation today. I am the current president of the Lincoln County Academy of Medicine and a nephrologist, a kidney specialist. With me is Peter McMain, a paediatrician. We will be making the presentation jointly.

At the outset, we wish to express our wholehearted support for the position on Bill 26, the Savings and Restructuring Act, taken by the Ontario Medical Association presented to your committee recently in Toronto by Doctors Warrack, Gray and Orovan.

My comments are going to be very brief because I'm going to let Peter McMain do most of the talking. I wish to make some observation, however, on Bill 26, focusing my attention on the possible impact it may have on patient-doctor relationships and possible detrimental effects it may have on the quality of medical care delivered to patients.

Since the days of Hippocrates in the fifth century BC, physicians have had a moral commitment to give the best possible care to their patients and to act as their advocates in this respect. The Minister of Health, in his drive to contain costs, appears to have come to the conclusion that every single clinical encounter the doctor has with his or her patient must be monitored vigorously, since they may create opportunities for fraudulent behaviour.

Measures that are particularly harmful and affect patient-doctor relationships and the quality of patient care are:

(1) Legislation to expand sets of circumstances under which the general manager of OHIP could refer a matter to the medical review committee of the College of

Physicians and Surgeons of Ontario and actually permit the general manager to bypass the MRC referral.

This latter aspect of the law may have been modified, since the Minister of Health last night stated that OHIP inspectors were not necessary, but he still leaves intact the intent of the legislation. In this climate of Big Brother looking over the shoulders of physicians, doctors may begin to indulge in defensive medicine to avoid practices that may be interpreted as fraudulent by the minister.

This has a potential to deter physicians from providing all the necessary services and from always acting as an advocate for their patients. Doctors may become reluctant to challenge the rules governing which services are appropriate. Soon, many physicians may find themselves conforming to the restrictions and deceiving themselves that they are acting in the best interests of the patient. Such a scenario would certainly be detrimental to the delivery of quality care to patients.

(2) Bill 26 allows the general manager of OHIP a general power to request the medical review committee to review physicians' provision-of-service patterns, even in the absence of reasonable grounds of any impropriety. This would involve a review of doctors' overuse of laboratory tests, diagnostic imaging, such as X-rays, CAT scans, MRIs and consultations with other physicians. The problem I see with this is that some physicians do see sicker and more complicated patients with very difficult diagnostic problems than some other physicians, requiring extensive use of diagnostic tests and second opinions to diagnose and treat patients appropriately. Restricting use of such investigative tools and opinions of other consultants would prevent the delivery of optimal care to patients.

I presume guidelines will be used to determine the appropriateness of investigative tests. Guidelines are developed from evidence derived from large randomized clinical trials. These clinical trials are carried out in well-defined, specified groups of patients, which in clinical practice may not apply to one's patients because they are outside these definitions and one cannot apply them. There are many grey areas, as pointed out by Dr Naylor recently in *Lancet*, and evidence-based medicine cannot always be used. In fact, it's in a minority of cases in your general practice. Just because one uses clinical guidelines that your peers and the university physicians have developed doesn't mean it can be employed in practice.

For instance, I deal with a lot of hypertensive patients. Huge, randomized clinical trials have been performed in the last 10 years that state that beta blockers and diuretics are the treatment of choice, but many patients cannot take these. It may be that a patient has asthma or there may be other lifestyle reasons. For instance, you can't jog very well if you're on beta blockers. The guidelines say to use them, but I use something else, much more expensive stuff, ACE inhibitors, and calcium channel blockers. Am I going to be penalized because of that?

1130

Young mothers of Ontario will have difficulty in finding a physician to deliver their babies because of the discontinuation of the physicians' malpractice premium supplements. Again the patients will suffer because of these measures. Some strategy must be worked out to solve this urgent problem.

Finally, although some closures of hospitals and emergency rooms are probably necessary, it cannot be denied that if extensive, it will be harmful to the interests of patient care. I do not think that limiting these powers to four years mitigates the harm it does, as stated by the government last night. The surviving hospitals will be told by the officials of the ministry to increase or decrease volumes of various services or to cease to provide specified services. This certainly threatens the quality of patient care.

In summary, constraints, for whatever reasons, envisioned by the omnibus bill will lead to deterioration of the quality and accessibility of care. I firmly believe that reform and restructuring of our health care system is necessary. However, in that endeavour, we must keep the interests of the patient foremost. I do not believe Bill 26 fulfils this goal. Thank you.

Dr Peter McMains: Chairman Carroll and members of the committee, I'm grateful for the opportunity to participate in these hearings. My name is Dr Peter B. McMains, and I'm a representative of the Lincoln County Academy of Medicine, an organization of which I am a past president, and I am engaged in the practice of paediatrics. To my left is Dr Elliott Halparin, who is the local OMA representative for district 5.

That our health care system is experiencing serious difficulties is an obvious reality, especially to those who are unfortunate enough at present to be ill. If the members of the committee take a random walk through any of the hospitals in this region, I guarantee that they will see peeling paint, crowded waiting rooms, long waiting lists for surgery; disgruntled patients being discharged home prematurely to be cared for by inadequate home care services; overstressed doctors, overworked nurses and disillusioned students.

The final ignominy is to see printed in the *Globe and Mail*, which I have here today, an ad by the University of Virginia Medical Centre advertising its ability to provide knee and hip replacements for Canadian citizens. Can anyone believe they would be advertising here unless they know of our long waiting lists for treatment? The last line of this ad is very pertinent to our situation. It says: "Pain doesn't wait. Neither should you."

We in the medical profession are fully cognizant that our province faces a fiscal problem of major proportions. With a provincial debt greater than \$100 billion and with 30% or more of the provincial budget being spent on health, we are in accord with the government that there is an urgent need to contain the costs, but we believe that Bill 26 fails to properly address the roots of our difficulties and will in fact compound them.

To put Bill 26 in proper historical perspective I wish to draw your attention to the evolution of our present problems. You will recall that in 1984 the Canada Health Act was firmly entrenched into the legislative fabric of our nation. It consolidated previous federal legislation and strengthened the federal commitment to the principles of universality, accessibility, portability, comprehensiveness and public administration. As such, it was the envy of the world.

The delivery of the act was attended with a euphoria of high hopes and expectations which one usually

associates with births. Unfortunately, a small caveat by Justice Emmett Hall was overlooked. With unusual prescience, he warned that the cost of the health care system was sustainable only if any further increase in service was proportionate to the rate of increase in the gross domestic product. In other words, "Don't get into deficit spending." Successive governments have ignored this advice. Whether it was through ignorance or whether it was to woo the electorate, I will leave you to speculate. But the net result is that the costs have spiralled upwards ever since.

During the 1980s, flush with profligate spending, the health service appeared deceptively robust. However, it was in reality seriously sick, with uncoordinated, fragmented services, unnecessary duplication of services, top-heavy administration and lacking proper vertical integration. As a result of this pathology, the health service corpus is now in a state of collapse, is seriously anaemic and in dire need of fiscal transfusion and intensive care—some might say the last rites.

We in the medical profession are tired of being blamed for what is essentially a political and administrative and consumer problem. With simplistic sophistry, we are blamed for the high cost of care because we are the gatekeepers of the system. The trouble is that the government took the gate off the hinges a long time ago. In reality, ours is a consumer-driven system with an insatiable appetite for service. Add to this the increasing cost of technology and it is easy to see why costs are getting out of control.

To date, most of the government's efforts to sustain costs have been directed at the providers of health care and not at the consumers. These problems, however, are not unique to Canada, and other countries have found workable solutions. In Sweden, probably the most socialized of European countries, a user fee is employed. Britain allows its citizens access to private insurance and private practice. Oregon in the United States, after consultation with health professionals and the public, has decided on a list of illnesses and medical procedures which the state insurance will cover, leaving self-limiting illness to be paid for by the patient.

To those who claim that adoption of similar measures here would lead to two-tier medical care, I reply that it already exists. In our hospitals we have private, semi-private and ward coverage. We pay out of our pockets for ambulance service. We also pay directly for artificial insemination, plastic surgery and certain eye procedures. Consider the newspaper reports of prominent politicians or their relatives who go to the USA for their cancer treatments or bypass surgery.

1140

The French philosopher René Descartes said that the two greatest impediments to clear thought are (1) haste and (2) prejudice. Unfortunately, Bill 26 fails on both these counts. Another old English adage says, "Act in haste and repent at leisure." The inordinate haste to pass such sweeping legislation represents, I fear, a panic reaction to a problem which has been years in the making. The problems are systemic and there is no quick fix. Prejudice is also manifest in the statements of the Minister of Health, who points to failed negotiations

between previous governments and the OMA as a reason for refusing to negotiate a mutually acceptable fee structure and compulsory arbitration in the event of unresolved disputes.

At best, the portions of Bill 26 relevant to health care represent a clumsy wielding of legislative authority which goes beyond the mandate accorded by the electorate. The uncompromising, coercive and indeed punitive tone of the bill sounds more in keeping with totalitarian regimes than those of a Western democracy. They also sound strangely dissonant with a government which espouses, as part of its political ideology, individual liberty and a free market economy. Indeed, there has been speculation that the health provisions of the bill represent the work of a cabal of civil service bureaucrats, served up to be regurgitated half-digested by a fledgling minister.

Schedule I of the proposed bill, with its provision through the Physicians Services Delivery Management Act, 1995, represents a blatant attempt to extinguish contractual rights and obligations. I find this ironic, when only last week Prime Minister Chr tien was asked if a change in Indian government would result in cancellation of contracts and he replied that governments respect signed contracts.

The provisions of the bill which effectively prevent physicians who work in hospitals to a right of hearing and appeal is an offence against natural justice and could lead to a court challenge. No matter the outcome of this challenge in the courts, I am sure that the Canadian public would be left with lingering doubts concerning the moral integrity of the government.

We object to the provisions contained in Bill 26 which empower the Minister of Health to unilaterally define insured services and set fees for these services. We object to the lack of provisions for settlement of fee disputes and an arbitration process. We object to being disenfranchised. We object to the loss of doctor-patient confidentiality which this bill will entail.

The ministry should be aware that the provisions of this bill leave very little room for manoeuvre on the part of our profession and could have disastrous results.

The portions of the bill dealing with physician eligibility and geographic billing numbers represent a crude attempt to conscript and exploit the young members of the medical profession for services in the rural areas of the province. The problem of providing medical services in these areas is a matter of prime concern for the members of the OMA. The factors inhibiting the recruitment of young physicians to these areas is due to facets of rural life, some actual and some perceptual. These are professional and geographic isolation, lack of technologically trained support staff, limited social and cultural activities, limited employment opportunities for spouses and fewer educational choices.

The answer to this problem is not to dragoon physicians into some kind of medical gulag, but to provide proper training for rural service and adequate financial incentives, subsidies and a mechanism for the provision of locums. I am also very certain that citizens living in these areas do not care to be treated by a resentful conscriptee.

Consider the plight of a new medical graduate, married

with a young baby and living in a metropolitan area where her husband works. The government proposes to dislocate her to a northern community before she can practise her chosen profession: Go there and proclaim the values of family unity to her patients. I find it rather ironic that the European Parliament in 1993 passed legislation allowing for the free movement of doctors within the European economic community while we set up restrictive barriers.

It is common knowledge that the cost of malpractice insurance is escalating and that for some branches of our profession the burden is particularly onerous. The removal of government contributions to the insurance will have the effect of decreasing the already small number of family doctors who practise obstetrics and will encourage the flight of obstetricians south of the 49th parallel. Senior experienced physicians who currently plug the holes in the system will no longer be able to afford the practice. The net result of this will be manifest, I regret to say, in rising perinatal mortality and maternal mortality rates. I am appalled that I now have to tell students that in addition to the long lists they have to know of the causes of perinatal mortality, they must now add to that list government parsimony.

It must also be pointed out that the government contribution to this fund was originally negotiated in lieu of a fee increase and that the government action now represents one further clawback.

Unfortunately, medical Utopia is still on a far distant shore, and like Ulysses of old, it seems that we will only get there by proceeding from one shipwreck to the next. If the good ship Ontario Health is to make it, then Health Minister Wilson, as master, would do well to consult as his chief navigator the Ontario Medical Association and to employ a willing crew of health professionals who have not been press-ganged into service. If we are to negotiate the shoals which immediately beset us, then the ship should be made more buoyant by consigning large parts of Bill 26 to the deep six.

The Chair: Thank you very much, doctors, for your presentation. We appreciate your interest in our process.

Are the nurses ready to go now?

Ms Lankin: Is there no time?

The Chair: No, the time's all gone. Are the nurses ready to go?

Mr Kormos: How much time did they have, Chair?

The Chair: Half an hour. Time flies when you're having a good time, Mr Kormos. Time flies when you're having fun like this.

NIAGARA COALITION OF REGISTERED NURSES

Mrs Margaret Clark: I would like to take this opportunity to thank Peter Kormos for the opportunity allowing the nurses to speak. Many of us are here on our days off. We were not one of the chosen few to be given time. My name is Margaret Clark. I'm a registered nurse at the Welland County General Hospital.

I would like to ask the panel: Who of you on this panel is prepared to give 24-hour care at home because a loved one has been sent home from hospital because

there are no beds or because of early discharge? Where do you get the skills to know when the patient's condition is changing? Do you know the signs of septic shock due to overwhelming sudden infection? What do you tell your employer if you have to stay home with someone? How does it affect your economic situation? Do you realize how little care is available in the community? The stress of the situation of having a critically ill patient to look after is better dealt with by the professional registered nurse.

I would like to call on Sue Gagné, who is a registered nurse at the St Catharines General hospital.

1150

Mrs Susan Gagné: Thank you, Marg. Thank you very much, Peter.

Mr Kormos: I should note as well, let's face it, that not being a member of committee and not getting that \$100-a-day tax-free per diem, I wasn't entitled to move a motion. It was Ms Caplan's motion, which we're grateful to. So this was a collaborative effort. There's a whole lot of people who are opposed to this Tory Bill 26, trust me.

Mrs Gagné: Thank you, then. As Marg said, my name's Susan Gagné and I'm a registered nurse at the St Catharines General. I work in the intensive care unit. I guess right now my only point of dismay is that I wasn't in Alberta when that man needed his heart. If you know the story, he couldn't get his heart because there weren't enough qualified nurses available to care for him.

My concern when I read the bill and the synopsis of the bill was with words: the words "without regard," "take over the powers," "no liability to government," "unlimited power," "remove requirements for citizen referendums," which to me implies full control by Bill 26 and the government to take over health care in Ontario.

Another statement that I hope everybody listens to, re-reads, is that of services prescribed "only if they are provided to insured persons in prescribed age groups." I hate to tell everybody in this room, but we can't stop the clock and we're all going to be in a prescribed age group whereby we might not be able to get the service or the care that we need. Frankly, when I'm 80 and I'm young and hopefully still interested in maintaining my health, I won't have somebody say: "I'm sorry. You're too old, Susan. Therefore you go without."

I'd like now just to briefly talk about the Health Services Restructuring Commission that is going to be set up to deal with this whole restructuring, re-engineering, rationalization issue. In my brief, it was stated that it will sunset in about four years. I think within these four years, then, we're going to have the health care corporations that are the determinants of health in the US, the Americanization of health care, come in and take over. It's interesting to note that the net worth of one chairman of one of these health care corporations is in excess of \$800 million. He's getting very rich for a service which isn't even available to all the people in the US.

I'd like to end my presentation now with once again the sunset in about four years. Probably if we carry on with Bill 26, we will see the sunset of our medicare system within four years. I would like to know how this government can believe that we should not fight against

the Americanization of health care in this province. I would like to know who is going to be the watchdog of this proposed Orwellian state that Michael Harris wants to create. Thank you very much.

Mrs JoAnne Shannon: My name is JoAnne Shannon and I'm a registered nurse at Greater Niagara General Hospital. As a registered nurse, I am speaking as a patient advocate. I am speaking on your behalf. Some day, everyone in this room and on this panel will be a patient requiring health care. The restructuring that is being proposed by Bill 26 will affect the quality of care that you receive. We've been reminded of the relationship between cost and value. Restructuring based simply on cost does not necessarily give value.

The re-engineering process that is currently being undertaken in this region with no input whatsoever from front-line workers is going to result in a less skilled caregiver who will be replacing the registered nurse at the bedside. The thrust of this government is to provide the best quality of care for the least cost. Does the least cost truly provide the best quality of care? Think about it.

Ms Margaret Dempsey: My name is Marg Dempsey. I'm speaking actually as a private citizen, but also as a nurse who works in the community. First of all, I didn't think I was going to have this opportunity, so the first thing I want to say is to express my feelings as a private citizen as to how offended I was by the government's intent to pass this bill without debate and without consultation. I did not vote for this government. There are members in this room, the opposition, who represent my views, speak for me, and they were not going to have a voice. Therefore, I was not going to have a voice. That's what I find offensive.

I definitely believe in the democratic process and I know that the majority rules. I have no problem with that and I have no problem with decisions being made that I do not agree with as long as there is debate and as long as opinions are heard that represent my feelings. So I'm delighted to have this opportunity.

Speaking as a nurse in the community, we do see things from a different perspective than in hospital care. I really think you have to consider the impact in the community at large on some of the provisions of this bill, particularly in regard to reducing or deregulating drugs and imposing user fees. I work particularly with the senior population. Seniors in their own homes often have great difficulty making ends meet on fixed budgets and so on, but they are also a different population in terms of how they perceive what they're going to spend their money on. Imposing user fees on seniors, and particularly confused seniors who don't necessarily understand the implications of some of these proposals, will inhibit them going out and getting the necessary drugs.

The interesting thing is, when we think about the health care system and we think about the fact that OHIP funds the entire system, be it the acute care, the community care process or the institutional care, everybody has their own little budget. The previous group that was speaking—I think they were a health insurance provider—made the excellent point of saying that we're not necessarily reducing costs; we're transferring costs. I believe that to be the case in many ways with some of

these proposals, because what's going to happen is you're going to get seniors not getting their drugs. They're going to end up in hospital. It's going to cost the government more. You just think you're saving money because you're reducing the cost by imposing user fees or by making it more difficult for these people to get their drugs, and in the end it's going to cost the system more because they'll end up in the hospital system, in the acute care system, and then finally into the institutional care level.

I have many more concerns. I wasn't prepared to speak, so I really don't know how to address them, but if you have any questions, I'd be glad to answer them.

Mrs Ecker: Thank you very much for coming at very short notice to this. I'm glad we had unanimous three-party agreement to allow you to come and I'm very pleased that you were able to do it. I appreciate the fact that—

Mrs Pupatello: Oh, save us.

Mrs Ecker: Excuse me. I have the floor.

Interjection.

Mrs Ecker: I have the floor. I'm very pleased that you were able to come forward.

Mr Kormos: Well, you weren't when they applied.

Mrs Ecker: It's unfortunate that when all three parties were drawing up their list of priority presenters—all three parties—we haven't been able to get more nurses' groups here before us. We had two excellent presentations—

Mr Kormos: All you had to do was say yes.

Mrs Ecker:—from two previous presenters on nurses.

The Chair: Mr Kormos, I believe Mrs Ecker has some interesting questions and these ladies have some interesting answers. I would like you to just let that process take place, please.

Mr Kormos: You've got it. But all the Tories had to do was say yes when the nurses—

The Chair: Thank you, Mr Kormos.

1200

Mrs Ecker: You make two very good points, which I frankly would share. I would join you on a barricade to fight against the Americanization of our health care system because I think that one of the things that Ontario has going for it is an excellent health care system. I had the experience of actually having to be there Saturday night in emergency with a loved one, so I know how valuable that system is. All of us have elderly parents and children and family members, and we know how important it is that that system is there to make sure it's there when we all need it. So I would certainly share that concern. I don't think that's what's happening, but I can appreciate your concern about that.

The second point and I just wanted to ask, you made the point about generic workers, and one of the things I think has been an excellent step in the health care system is the Regulated Health Professions Act, which very clearly sets out scopes of practice for regulated health professionals, which include nurses, which are starting to include nurse practitioners, and I think that the quality objective of that legislation is supported by most observers of that system.

I have concerns about generic workers in terms of what that might be doing to undercut what the RHPA has built up. I just wonder if you would like to elaborate a

little bit more on what you see is happening with some of those generic workers, because I share your concern on that.

Mrs Shannon: We don't have them currently, but the move is towards them and that's our concern. The multi-skilling of other workers is beginning. They're beginning to break down what we do into tasks. Our concern is that these tasks will now be given away to less skilled people, who we will still be responsible for supervising and making sure that the care given is quality care. I don't think the generic worker is out of place not giving direct patient care. Direct patient care should be left to professionals, but there is a place for them in non-direct patient care.

Mrs Gagné: I was just going to say my concern with the generics is you're basically chopping up the patient into bits and pieces. In order to really care for somebody, meaning from the time of admission, the goal is to get that person back to their return to activities and to earning a living. Okay, that's the goal. If you chop that person up into different little pieces, I'm concerned that the return to activities of daily living might be compromised, and that person's not going to realize full or the best potential recovery.

As simple as it sounds, the bed baths—so we'll give the generics the bed baths. There is so much information gleaned from that time with a patient. The other thing is that that's where the health teaching care is on, during that time. You can't trivialize these things. It has to be in the whole package. If you have someone who has the knowledge base, the critical thinking skills, to do those seemingly menial tasks, the outcome is going to be more successful.

Mr Bradley: I'm glad that my colleague Elinor Caplan was able to move the motion to have you appear before the committee today. I know it has received support from the members of the opposition and today the members of the government.

My first question is, and I'll let any one of the three of you answer as citizens of our society, the members of the opposition had to take extraordinary legislative action to ensure that we would have meaningful hearings in the month of January when everyone would be attuned to them and, second, across the province where people from various communities could have input. Do you believe that the opposition did the right thing in taking extraordinary legislative action to ensure that we have these hearings?

Ms Dempsey: Absolutely. I was delighted. As I said earlier, I really believe that we need to have a voice. That's the parliamentary system from my understanding, that we have an opposition that expresses the voice of the people as well as those who are in government, in power. This to me is essential debate, because it is very precipitous to implement something this profound in such a short time frame and with no debate.

Mr Bradley: Subsequent to that, do you believe that further hearings across the province past the January 29 date that the government has set would be useful to enable the government and enable the opposition in the Legislature to ensure that whatever legislation is passed is a better piece of legislation, better reflecting the views

of those who are aware of the consequences?

Ms Dempsey: I would say, again, absolutely. I think we don't appreciate the implications of something like this. To hear those who are actively involved in the direct care of individuals, particularly within the health care system, the implications are many and, as I said, I don't believe that what you're doing is necessarily cost-effective. It may look cost-effective at this moment in time with the information you have, but if you consider the bigger picture, you may find that in fact it's going to cost a lot more money than you expected it to.

Mr Bradley: One of the differences between Canada and the United States I think that people objectively observe is the health care system and the attitude of our citizens towards that system. The United States has lower taxes; we have, I think, a better health care system. Given the choice, do you believe that the people of this province would rather have a 30% cut in their provincial income tax or that they would rather have that money remain within the health care system to provide for people in this province the kind of quality health care that we would like to have for many years to come?

Mrs Gagné: My answer is yes. But my answer is yes, as long as we do realize a maintenance of what we currently have and we don't have the user fees and we don't have the \$150 per member per month—and that's a union phrase, sorry, but all the extra fees added on top. I don't know. Right now, I'm a bit cynical. I think I have to see from this government true sensitivity.

When I see the Premier on TV and his response to the labour movement in London—and I have to say that my dad, he's 74 years old and he marched in London—and his response was, "Yes, well, I know they're going to be upset." I think if the public can see some true sensitivity from this government to maintain health services, we might start believing them.

Mr Kormos: Ms Clark may want to join us by sitting in this chair here. I want to ask you a question, Ms Clark. Hospitals in this province are basically private institutions with boards of directors picked out of a very small, incestuous group of people who are inclined to join the hospital association. In the Welland County General Hospital, I'm told that the members of that association number no more than 200, and out of that mere 200 comes a board.

Because it's public moneys that by and large are spent in our hospitals, would you agree that one of the ways to really start addressing the issue of accountability in where the money goes is to have publicly elected boards, in view of the fact that hospitals are spending taxpayers' money in such huge amounts?

Mrs Clark: Definitely. This has been one of my top priorities in Welland, constantly, constantly going to the board members and saying, "I want the board to be elected and I want it to be open." They refuse, absolutely refuse, to allow any employee of the hospital to sit on the board, and unless that is legislated by this government, it will never happen.

The only reason that we nurses and other union members are sitting on fiscal advisory committees today is because it was legislated. For years we've been fighting to sit on these boards and they have refused to

allow it. This board is the board that reviews the whole operational budget that the hospitals get, and we've only been on them now for about four years. Now our next fight is to get on the hospital boards themselves, because this is where the decisions are made.

Mr Kormos: Nurses as the front-line service delivery people, you're the folks, women and men, who are with our parents and our family members and ourselves when we're ill. You're with us 24 hours a day. Nurses have been prepared—quite frankly, isn't it nurses who have the best input into concepts of restructuring and finding efficiencies and finding economies that haven't been discovered before? How come you haven't been more actively involved in that process? Why are people slamming the door in your face?

Mrs Shannon: We have not been allowed to be part of the process. As RNs we recognize that the health care system needs to be restructured, but we would like input on how it's restructured. We feel, as patient care advocates being at the bedside 24 hours a day, we know what is waste and duplication in the system.

Mr Kormos: You may or may not have read about these two little brochures, unendorsed, unsigned, paid for by all of you taxpayers of Ontario, printed by the government, which contain—it's called spin-doctoring, it's called damage control. The Tories spend thousands of bucks, hundreds of thousands of bucks on spin doctors and damage control people. They've got their little staff people here, four or five of them, who review what's heard here today and then advise this panel of Tories on how they should be responding so they can control damage.

One of the things that these most deceitful and dishonest little bits of hack propaganda indicate is that Bill 26 was held with extensive consultation—expensive too, expensive to the sick and the elderly and the poor in this province—with the stakeholders. Were nurses consulted in the course of the preparation of Bill 26?

Interjections: No.

Mr Kormos: Would you have been prepared to sit down with this government or any politician and discuss goals for restructuring and economies?

Interjections: Yes.

Mr Kormos: Well, I think it's disgraceful. It seems that the Ontario Hospital Association is becoming increasingly satisfied and complacent. I have no doubt that Dennis Timbrell and his gang, being related almost by blood as he is with this gang of Mulroneytes and Reformers in Queen's Park, were consulted.

I want to tell nurses in this region and in this province that you are the women and men who attend to our sick on a daily basis, 24 hours a day. You're the ones who suffer the injuries, who suffer the bad backs and other workplace injuries associated with the very physically strenuous as well as mentally strenuous and demanding task of nursing.

This government clearly devalues and dismisses the public sector, be it public sector in broader public sector nursing in our hospitals, be it public sector nursing in our communities and the prophylactic role that they play in terms of preventing disease and preventing illness and creating economies that way. I think it's disgraceful that

nurses should come under attack by a government.

Mike Harris promised no reduction in health care. Well, by God, the impression that a whole lot of people have is that Mike Harris lied. It was a bold-faced lie, it was an unabashed lie and it's a lie that's being demonstrated now by virtue of these hearings on Bill 26. It's an indefensible lie and a shameful lie, and I encourage you people to keep fighting back.

The Chair: Thank you, ladies, for your presentation. We'll now recess under 1 o'clock.

The clerk has the amendments that were handed out to the other half of the committee.

The committee recessed from 1214 to 1301.

JOHN DAWSON
NIAGARA FALLS AND DISTRICT
LABOUR COUNCIL

The Chair: Good afternoon, ladies and gentlemen. Welcome to the resumed committee hearings on Bill 26. Our first presenter this afternoon is John Dawson, who's a regional councillor.

Mr Kormos: Mr Chair, please, I appreciate that the Chair is trying to be timely, but the fact is that obviously committee members are still en route back from their lunch; perhaps they're making phone calls, any number of things. Could we defer the commencement of this for five minutes so that committee members have a chance to—I mean, why should people bother making a submission if people aren't here—

The Chair: Mr Kormos, if you had been with us for the last 14 days and the last 11 sittings, you would know that as a committee we agreed to this procedure.

Mr Kormos: It's the rights of these people to be heard by members of the committee. Just wait five minutes—

The Chair: You've got a half-hour of our time to use as you see fit.

Mr Kormos: —so that the balance of the committee members can get here.

The Chair: Questions, should you allow time for them, would begin with the Liberals. The floor is yours.

Mr Kormos: Mike Harris obviously lent you his jackboots today.

Mr John Dawson: My name is John Dawson. I'm a regional councillor for the municipality of Niagara. To my right is Mr Wayne Hardwick, who's vice-president of the Niagara Falls and District Labour Council and former president of the Ford glass union.

I have here a document that I was going to pass to the Conservative caucus, but I find that most of them are not present once again. Perhaps I'll wait till after I give my submission. It is on the supposed long-term care reform model which necessitates the establishment of a new agency to operate the placement coordination and home care services.

Copies went to the Conservative caucus and I might just mention here that it says: "In these times of scarce tax dollars, I do not understand how the dismantling of programs which are now functioning very efficiently justifies the spending of limited government funds to establish a new governance organization." I know that copies of this letter from the regional chair went to the

local MPPs and I might just pass it around to get their comment on this matter. Also, it says, "During these difficult times, the community needs to pull and plan together, rather than become more divisive with the creation of a new agency. Our regional council representatives are reflective of our entire community."

Maybe I'll pass this over to you and you can have a look at it and have comment.

Thank you for allowing me to appear before this committee to express my views on what I consider to be a decline in health services as a result of Bill 26 and other government legislation. The thoughts I express are my own and not those of regional Niagara.

Health care costs amount to approximately 6% of GDP and are no doubt well worth the expenditure. High interest rates, interest on the debt and diminishing federal and provincial revenues are all additional factors that contribute to that problem. Health care costs are not, I would argue, a serious area of concern in relationship to the deficit.

One of the Conservative panel members, who has not arrived back yet, I might say, referred to the \$1-million cost per hour required to reduce the deficit. I would like to just comment on that by relating a little experience I had at my favourite financial institution recently. I was there to renew a matured investment and naturally the young lady was eagerly trying to convince me to reinvest at that particular bank. My response was, "Ms, my country is in trouble, my province is in trouble; the banks are not in trouble." I proceeded to purchase an Ontario savings bond, much to her disappointment. If my memory serves me right, the Ontario treasury was, from all the purchases of the bonds, richer by over \$2 billion. The money stayed in the province and did not go abroad to foreign bond holders.

I began to think about the loudest and most vocal critics of our health system, as well as the debt and deficit: the corporate community. Are they concerned about our province, our country, our health care system, when they pay only 7% to 10% of their profits in taxes? One writer in a Toronto newspaper recently—and this is not the Toronto Sun—said that Alcan owes the federal government \$1 billion, probably in unpaid or deferred taxes. Finance Minister Paul Martin's company, CSL Group Inc, made a pre-tax profit of \$19.7 million in 1990 and paid no income tax. They received tax credits equalling \$400,000 as well. This lack of revenue federally worsens the provincial scene when they also reduce the transfer payments. Are the corporate community and the profit-hungry banks concerned about our province, our nation, our health system? Does their conscience not bother them that their inadequate contribution to the tax burden is helping to destroy a good health system in Ontario?

You, as elected members of the provincial Legislature, should concentrate your efforts in persuading the federal government to bring in a fair tax system so that Ontario's health care system will not deteriorate any further. Prominent Conservatives like Mr Dalton Camp are highly critical of the Klein and Harris agendas—much to your embarrassment, I'm sure.

Some doctors are saying that Bill 26 may influence

their decision to practise here in Ontario, so that portion of moneys spent by the province to finance their education will be lost.

Bill 26 gives the Health minister sweeping powers and authority to close hospitals, taking power away from local communities over their own health care. The local district health council did not receive any approval from peninsula residents to make major changes to local hospitals or health service delivery systems. At any meeting I attended, those in attendance were opposed to drastic changes. Improve it, yes, as the previous government had been doing.

The Harris government promised not to cut health care, yet we discover \$1.3 billion is to be taken from hospitals over the next three years. The Premier promised not to introduce user fees in health. Now, come next June, seniors and welfare recipients will have to pay user fees for prescription drugs. Seniors will have to pay the first \$100 per year for their medically necessary prescription drugs, plus more than \$8 for each prescription. This will cost seniors, many with limited finances, hundreds of dollars more per year. Drug prices are likely to soar, because under Bill 26, Ontario will be the only province that does not set a price ceiling.

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One of the most ominous parts of the omnibus bill is that it opens the door to disclosure, as many people have mentioned today, by government officials to a citizen's private medical records including information that should remain completely confidential. This legislation, if passed in late January, will encourage private US companies to open more private health clinics, opening the door to a two-tier health system. Projected population increases, especially at the senior level, are not being taken into consideration with your unplanned dismantling of our health services. Hospitals, seniors' homes and other health care infrastructure may indeed be required for future population increases. The people of Ontario value their efficient health care. You weaken and try to destroy it at your peril. We are prepared to fight back.

Thank you, Mr Chairman. I'd like to turn it over to my co-presenter, Mr Wayne Hardwick.

Mr Wayne Hardwick: My name is Wayne Hardwick. I'm the vice-president of the Niagara Falls and District Labour Council, representing some 4,500 union members in the Niagara area, and I am pleased, along with my colleague Mr John Dawson, to be able to participate in these hearings and to express our concern and opposition to the far-reaching, undemocratic implications contained in this health care section of Bill 26.

The following pages examine just a few of those provisions of the act. The extensive nature of such a bill is such that all of the important amendments proposed demand more time and analysis than is available, given the government's attempt to railroad through this omnibus legislation. A detailed analysis and full democratic discussion must be available to all citizens of Ontario in order to fully understand its ramifications.

Under schedule F of the bill, this section amends the Ministry of Health Act, the Public Hospitals Act, the Private Hospitals Act, and the Independent Health

Facilities Act.

The changes to the Ministry of Health Act create a new Health Services Restructuring Commission which one suspects is designed to provide cover for the government on unpopular decisions like closing hospitals.

The Public Hospitals Act is amended to give the Minister of Health unprecedented arbitrary power over hospitals, including the right to appoint a supervisor to basically take over the hospital.

In the Independent Health Facilities Act it becomes more evident that the government is trying to facilitate the privatization of health care. The bill gives the minister broad new powers to designate new services and facilities to be covered by the act.

The omnibus bill repeals the existing subsection 6(3) preference for non-profit facilities for Canadian ownership. This is an obscure section worth emphasizing. If the government's intention is not to encourage American for-profit companies to take over more of Ontario's health care, then what is the intention of this clause?

Further changes indicate that it will be easier to charge patients—a new word—"facility" fees for health services.

Schedule G amends the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act, 1991. As advertised, this introduces copayments and deductibles for seniors and social assistance recipients. It also deregulates drug prices. The new name of this act is the Drug Interchangeability and Dispensing Fee Act, since it no longer regulates costs.

Ontario will become the only province that does not regulate drug prices. The government will say deregulated drug prices will go down, but there's no reason anyone should believe this. Or perhaps Ontarians with health problems will be expected to haggle over prices with pharmacists, as they do with grocers over tuna.

The Ontario drug benefit user fee or copayment will come into effect on June 1, 1996. The prices for drug products will be set by agreement with the manufacturer and they will replace the best available price, BPA, mechanism now utilized.

The markup percentage on drugs will no longer be restricted to between 10% and 20%, as it is now. The markup will be set by regulation. The minister's office says this will "allow for greater flexibility."

The government will no longer pay the difference between generic and brand-name cost for no-substitution claims. If a generic drug is not suitable, the individual must pay the difference between the generic and the brand name.

Special provisions will be added to allow the ministry to collect, use and disclose only the regulations that restrict what information is collected.

The government will set the maximum Ontario drug benefit dispensing fee by regulations. Under current legislation, negotiations are made between the government and the pharmacists. Now the government will set the dispensing fee by regulation. When asked why this change is necessary, the minister's office staff replied that it was never a useful process to negotiate with pharmacists.

Schedules H and I: Schedule H amends the Health

Insurance Act and the Health Care Accessibility Act. Schedule I creates the new Physician Services Delivery Management Act, 1995.

Together they provide the government with enormous powers over doctors, from whom I'm sure you're going to hear today. The Minister of Health can restrict the number of eligible physicians, determine that a particular area is oversupplied and impose a moratorium in new eligible physicians in that area.

The amount paid for services may be varied, depending on the geographic area and other factors. One amendment to the Health Care Accessibility Act, subsection 2(3), may open the door for hospitals to expand their user charges for such items as toothpaste.

The Physician Services Delivery Management Act treats doctors like the Leamington mushroom workers who were decertified with the repeal of the Agricultural Labour Relations Act. It voids the OMA's agreement, strips the OMA of any negotiating rights and says a judge's ruling, decision, award or order to the contrary "shall be of no force or effect." In that case, they're above the law.

Schedule K: Bill 26 amends the Freedom of Information and Protection of Privacy Act and the Municipal Freedom of Information and Protection of Privacy Act.

The essence of these amendments is to make it harder to gain access to documents and, conversely, easier to deny access. Institutions will be able to deny access on the grounds that a request is "frivolous or vexatious." It will be easier to dismiss appeals when access is denied.

Bill 26 gives the Minister of Health new powers to obtain confidential health information and disclose it to whomever he chooses. While the minister says he only wants to combat fraud, the bill says the minister "may disclose information obtained under the act if...(he) is of the opinion that the disclosure is necessary for the more effective management of the health care system or for the delivery of health care services." This is a dangerously broad mandate.

Schedule L: This schedule amends the Public Service Pension Act and the Ontario Public Service Employees' Union Pension Act, 1994.

These changes facilitate privatization and downsizing because they eliminate the danger that the superintendent of pensions or anybody else might order that the public service pension plan or the OPSEU plan be wound up, in whole or in part, in the interest of this group of employees being cut loose through privatization or downsizing or whatever.

These two acts are now exempted from previous provisions of the law that require that they be wound up at least in part when a "significant" portion of the employees are terminated. There have been cases where this has been ordered when less than 20% were terminated.

Winding up the plan is better for the employees being terminated, mostly because many people who are short of full pension are allowed to "grow into" an unreduced pension at, for example, a factor of 80. That's a combination of years and work service. But winding it up is also more expensive for the employer.

If the government lays off 20,000 government

employees, as it is expected it will, should this bill be passed, it will have the authority to deny full pension benefits to those people. Thomas Walkom of the Toronto Star, on December 7, 1995, puts it this way: "In effect, it will be able to cheat public service pensioners of between \$400 million and \$500 million worth of money owed to them." These amendments are retroactive to the day the OPSEU plan was established, January 1, 1993.

1320

Schedule Q: This schedule amends the Fire Departments Act, the Hospital Labour Disputes Arbitration Act, the Police Services Act, the Public Service Act and the School Boards and Teachers Collective Negotiations Act.

Working people covered by legislation that denies them free collective bargaining and instead forces them through their unions to submit to compulsory legislation now face even further restrictions. Teachers, firefighters, police and, in this instance, hospital workers are now subject to the restrictions of Bill 26 which inserts statutory criteria which an interest arbitration board is required to consider when it is making a decision or award.

Arbitrators will now have to consider:

The employer's ability to pay in light of its fiscal situation.

The extent to which the services may have to be reduced if the current funding levels are not increased.

The economic situation in Ontario and that of the municipality or municipalities concerned, except for the Public Service Act where only the economic situation in Ontario is to be considered.

A comparison on the terms and conditions of employment and the nature of the work performed with other employees in the broad public sector.

The employer's need for qualified employees.

These provisions constitute a significant interference with the independence and integrity of the arbitration process and must be opposed. Traditionally, boards of arbitration have been extremely resistant to looking at the criterion of ability to pay since it could require public sector workers to subsidize the provision for public services and also since it usually equates more readily to the willingness of an employer to pay.

Although arbitrators will only be asked at this stage to consider the criteria, presumably employers will be asking arbitrators to impose significant pay cuts given the government's funding cuts.

In conclusion, on Tuesday of this week, approximately 1,000 employees at Toronto area hospitals were laid off as part of their downsizing and/or restructuring, which will lead to closed beds and reduced services. As Bill 26 is not legislation at this time, this is obviously an omen of things to come.

Our local hospital, the Greater Niagara General Hospital, of which I am a board member, has been in a restructuring mode for some time and has been touted as one of the most efficient in the area. But increased funding cuts will negatively impact this facility with job losses, closed beds and services, putting patients and emergency services at risk.

Where have your government's commitment and campaign promise not to cut funding and quality of health care gone? The hospital workers, patients and

residents of Ontario expect first-rate, quality health care. Nothing less is acceptable. Thank you very much.

Mr Bradley: First of all, I appreciate your representations. I thought they were very much to the point. I want to zero in specifically on the health aspects of the bill and one of the implications I heard this morning that you would no doubt be interested in.

Is it your concern that employers, faced with additional costs in the field of health care, as Liberty Health said this morning would happen, will now begin to initiate activity involving the stripping of contracts of those fringe benefits which relate to health care? What are the implications of that?

Mr Hardwick: There is no doubt in my mind that is exactly what is going to happen. This government said they would give employers the tools to cope with their workers' collective agreements, and this is a way of underhandedly undermining the collective bargaining process which every worker has a right to have, the process of bargaining. They're taking that away from us.

Mr Dawson: I share the concern of my co-presenter in that question as well. Could I ask, Mr Chairman, if the Conservative caucus had a chance to read the letter from the regional chair and would like to comment on it.

The Chair: The questions are in order here. Each party has only two minutes of the time left, so they may have to do that independently.

Mr Dawson: It's very important. The agency they created for long-term care was a duplication and is inefficient and wasting money at the regional level and I thought they might like to comment on it.

Mr Bradley: What will be the—

The Chair: Thank you, Mr Bradley. Mr Kormos.

Mr Kormos: Some of them are reading it. I can tell. I can see their lips moving, Mr Dawson.

You asked what happened to Mike Harris's promise not to cut health care. Well, obviously it wasn't a promise, it was an outright lie. So to query what happened to their promise is moot.

Gentlemen, I want you to know this: This committee has spent one week in Toronto, and now is just wrapping up its second week in communities across Ontario, purportedly listening to people in the communities. Obviously Niagara is no different from every other jurisdiction that this committee visited. It refused to accommodate all those people who wanted to make submissions.

You've got to understand that this committee has three full-time standing Tory members plus the Chair, one New Democrat, one Liberal. I want to apologize to you, because these are all MPPs who make around 65 grand a year plus—if you're in the government especially, when you get the perks for being a Chair or a Vice-Chair or a parliamentary assistant—each member of this committee also receives a \$99-a-day tax-free per diem, an honorarium just for doing what they're normally paid for.

I want to apologize for the Tory caucus, because I know Mrs Ecker, who arrived but then disappeared again, who is a voting member of this committee, was not here during the course of your presentation. I submit to you that apologies are in order. It may seem peculiar that I should apologize for a member of the government with whom I have little in common, but I think apologies are

appropriate.

Here's a member who's making her per diem, who's earning her full MPP salary, who purports to be committed to this committee, yet obviously has no interest. Now, what that illustrates is that this government, its spin doctors and pollsters and little media relations people, try to create the impression that they're listening to people while the facts speak for themselves. Clearly the members of this committee have no interest in what you or others have to say. Their absence from this committee, when they're paid members of this committee, illustrates that in a most graphic way.

Mr Tim Hudak (Niagara South): Gentlemen, thank you for your presentation today. I've a question, if I have time, one for each of you. First, Mr Hardwick, if I may. I'm a representative of the Niagara Peninsula. I think roughly one fifth of the population falls in my riding. It covers the Falls, and then more rural communities like Fort Erie, Port Colborne and Wainfleet. This area is underserved in terms of GPs. I think we're close to 5% underserved. The OMA and the previous government had five years to try to solve this problem, to get more doctors into the peninsula. A solution hasn't come forth in that area. One of the recommendations we have heard is for the minister to limit billing numbers to ensure that doctors will practice in underserved areas. What's your opinion of that and what kind of answers do you have to get more doctors into the peninsula?

Mr Hardwick: First of all, I'm really not going to comment on whether there should be more doctors. That's not my field. I'm not a doctor. All I know is right here in Niagara Falls I have my doctor, I have my health care, I'm satisfied with that part of the health care system. As for the rural areas, you'll have to have somebody from that rural area come down and answer that question. I'm sorry. I can't do that for you.

Mr Hudak: Fair enough. I understand that. I know that was an issue with a lot of people that I've spoken with, union, non-union members.

Mrs Pupatello: Your bill is not helping your area.

Mr Hudak: I'll move on to Councillor Dawson. Good to see you again. I enjoyed your presentation, like last week's. I just want to hit on one issue that you touched on, and that's the district health council report. In your opinion, how has the visiting process gone so far? How do you feel the public input has been in the DHC report so far as the minister is going to listen to?

Mr Dawson: I attended several meetings over the past year that were sponsored by the district health council. For example, at one meeting they had Dr Fraser Mustard, and his comment was, "Beware of the zombies," I think, and he referred to you people on the far right that wanted to dismantle our health care system—you and the Reform Party because you're so much alike.

I got the impression, sir, that the district health council was not listening to people. They were making recommendations. People who went up to the microphone were strongly in favour of retaining our health system, yet they were making recommendations to the government that were not based on public input.

The Chair: Thank you, gentlemen. We appreciate your

presentation here this afternoon.

1330

Ms Lankin: On a point of privilege, Mr Chair: I believe that my rights as a member of the Legislature have been violated, and I'm referring specifically to an amendment we were given a copy of this morning. These amendments, a few of them, were tabled in the other committee dealing with the non-health sections of Bill 26. The very first amendment is an amendment of the Municipal Act which sets out that no bylaw under which a municipality can impose a fee can be done in the form of an income tax, a poll tax, a gas consumption tax etc.

I want to refer you, Mr Chair, to the fact that in direct questioning in the Legislature of Ontario, when we put the question to the Minister of Municipal Affairs of whether or not Bill 26 allowed for municipalities to impose poll taxes, head taxes, gas taxes, he said unequivocally that it did not. In fact, I will read to you from Hansard. He said, in an exchange with Bob Rae, the leader of my party: "I wish the honourable member across would read the entire bill. It says this legislation allows fees and charges to be applied on services provided by the municipality. That's what it says. Read it. It does not say, and it does not apply to, sales tax, gas tax, property tax or any of them. You're wrong."

In further conversation with Mr Rae in the Legislature he says, "I'm going to repeat it one more time: Read the legislation. You are wrong. I'd ask you to resign if you were wrong, but you're on your way out anyway. The legislation is very, very specific. It speaks. The legislation allows fees and charges to be applied to services by the municipality. Read it."

He goes on to say, "Yes, because the act doesn't allow it. The act doesn't allow any kind of charge. Read it. It doesn't allow sales taxes, gas taxes or any of that type of tax just by definition. I think you'd better go back to your lawyers and get them to look it over again. It's very clear to us. It does not give the municipalities the tools to impose a gas tax."

Later that day, in response to a question from the media, the Minister of Municipal Affairs, the Honourable Al Leach, indicated that in fact he knew his legislation, that he was right and that if he was wrong, he would resign.

I want to place on the record today on behalf of the New Democratic caucus, the call that was issued by our House leader, Dave Cooke, in Toronto today, that given they have now tabled a motion to amend Bill 26 to clarify the very points that Bob Rae and the New Democratic caucus and that Lyn McLeod and the Liberal caucus and that many municipalities made over and over and over again, that Bill 26 did in fact in its original form allow for those taxes to be imposed, now that the government itself has had to put an amendment in to stop that action and Mr Leach is absolutely wrong, I repeat the call and I place it on the record today. It is time for him to live up to his promise to the people of Ontario and tender his resignation from his position as cabinet minister.

Mr Kormos: He's either incompetent or he's a liar.

The Chair: Ms Lankin, that is not a point of privilege.

Ms Lankin: Mr Chair, I beg to differ. I indicated that

my rights as a member—

The Chair: Ms Lankin, if you beg to differ, you will have to take it up with the Speaker of the House. I've made a ruling. It's not a point of privilege.

Mr Kormos: You're the Chair. Leach is either incompetent or he's a liar. Which one?

The Chair: Our next group is the Niagara Falls Seniors, represented by Ray Wilson.

Mr Dominic Agostino (Hamilton East): Mr Chair, before you go to that, could I quickly table with the committee—it's not a point of privilege. I was in North Bay last night at a hearing in the Premier's riding, where obviously the Premier refused to hold public hearings, and a number of groups came forward. Over 100 people attended a hearing and on their behalf I want to table to this committee, so the Premier can take a look at what people in his own riding are saying, the briefs that were sent to us last night on behalf of the people of North Bay to this committee. The Premier of Ontario can find out what people in his own riding have to say.

The Chair: Okay, Mr Agostino. The clerk will pick them up from you.

RAY WILSON

ONTARIO NETWORK OF INJURED WORKERS GROUPS

Mr Ray Wilson: Thank you, ladies and gentlemen, for the opportunity of being heard here this afternoon and allowing the democratic process to be expressed. One of my children came home this past week and said, "Dad, did you hear the latest Bob Hope joke?" I said, of course, no. He said: "You know all the women that I've tried to date must be very religious. Every one of them told me that I didn't have a prayer." I hope that isn't the case in the presentation of my brief today.

I have been very successful in the past. I've been a political activist for some 40 years, and along with Premier Davis, at one time we were able to establish the park at Effingham Hills. So that is one of the attributes of your previous Premier.

However, Chairperson, as a concerned citizen who has paid his way through his life, I take offence at the changing of the health act if it means additional cost to us. The idea of making an alternative drug available if it is cheaper and does the job is a reasonable conclusion, providing it meets the standards of the health board. But we are concerned that, with this Bill 26, it will not give us the results that are desirable.

I am one of the oldest taxpayers in our community, who has worked very hard for what we have in Ontario, and I am dedicated to protect it however I must. We have never taken anything from the government, raised six children and taught them the honesty of the work ethic, and as parents we are proud of all of them. We now have a total of 35 in our family and we are very concerned with their wellbeing.

Our governments have made Ontario, if not all of Canada, a place where we are at risk in many areas. Pollution of our environment has made us all prone to many of the afflictions that are making many of us ill today. Some years ago I was a pioneer in the environ-

mental field. Studies proved then what was happening to our air, water and soil, but unfortunately, to some degree it fell on deaf ears. Today we are reaping what we have sowed. In many instances, our companies raped our lands, and we paid them to do it. Must we pay again for this atrocity?

I quote the St Catharines Standard dated December 26, 1995: "Governments are attempting to cure sickly financial situations by tossing elderly patients out of hospitals and into homes with inadequate care. There used to be tribes that sent old people out in the cold to die. Is this what we are coming to? Will those who occupy chronic care beds be told to find other places to live? There is a waiting list now in certain areas. It takes years to get into a government-subsidized nursing home."

This is the same scenario that existed 25 years ago, when I had documented cases where these folks had no place to go, their children didn't want them, so the police would come and pick them up and place them in a cell for the night. Because of this inhumane treatment, we circulated petitions in our city to have Dorchester Manor built. It was a big battle at that time, and the churches and labour supported us well.

Canadians are a people who will put up with a lot, that's our nature, but perhaps it is time for expressing again. We have built a province that was the envy of all provinces, but we were naïve to think the politicians would carry on this great heritage.

Our young people see the situation for what it is today. Many who have become educated want to obtain jobs and pay their way but find it hopeless. Is this the kind of country we are building today? If it is, then we should hang our heads in shame. We told them they must get an education, and they did, only to realize our factories are shut down and moved somewhere else. These youngsters see what is happening quicker than we did.

Because of our attitudes, our politicians again want to burden the segment of society that is the most vulnerable. Family life is fast becoming a thing of the past. Look for a moment at the statistics of broken homes, single-parent families. At last count, there were 180,000 children in Ontario going to school hungry every day.

While the rich get richer, the poor become poorer. There are many in this province who are making a good income but never pay a penny tax. Some of the largest businesses never pay taxes. Why?

We introduced lotteries a number of years ago. We never in our wildest dreams expected the revenue that it generates today. And the profits, where do they go? They were supposed to go to hospitals. Well, maybe a pittance does, but I believe most of that money goes into the general fund, along with the other taxes that have been imposed upon us.

Our income has been reduced this past year some 2.5% because of inflation. We lost our municipal tax subsidy, and the list goes on. In many of the communities across Ontario, most of the volunteers who perform the little jobs that make a community click are performed by seniors. With this change, do you think we will be able

to do them? Many of our seniors have had to sell their homes and move into an apartment. If this is compassion, then we had better go back to school and learn what it means. Our governments have declared they will cut social programs to the bone and allow further tax cuts for the wealthy in our society. We cannot in the autumn of our years allow the unscrupulous pilferage of the Canadian way of life.

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As the Spicer commission pointed out so ably, Canadians are at the mercy of a group of political and media élites who are trying to dictate the future of this country. These high priests of the media-political Canada are themselves a minority group among the 4,000 or 5,000 who hold power over the real Canada. As Mayer Anselm Rothschild has said, "Permit me to control the money of a country and I care not who makes the laws."

The Minister of Health declared a few weeks ago that he was slashing \$132 million from this year's budget; \$9.7 million less for hospitals. Four birth centres will be closed and several medical research programs will be axed. When these facilities are closed, is the loss of money incurred when this office equipment is sold or the expertise of the employees who administer these programs ever considered? There must be a lot of office equipment out there for sale at fire sale prices.

We realize the fraud with the present health card system and were assured at election time this would be corrected with the use of photographs. Now this is set aside, in spite of the fact that it would save health care dollars as it would reduce fraud. If this is what the Common Sense Revolution is all about, it is time it's repealed.

There was a commitment to create 725,000 jobs. Where are these? We are shutting our province down. We are no longer doing business. According to statistics, in the first four months after the election, employment fell by 20,000. Is this the proper way to operate our province? Even I, as a farmer, know that you must spend money to make money. We acknowledge the fact that the federal government has cut \$9.5 billion over the next five years. We have been cut more than any other province. Some 44% of our national debt is due not to us in the marketplace but is due to the tax breaks to large corporations. Taxes owed by large corporations in 1993 were \$1.45 billion. If it was me, you would lock me up and throw the key away.

In 1990 the government realized the need for home care services and allocated some \$70 million. They recognized a need and took care of it. Funds were allocated for the development of 25 new elderly centres and, in addition, \$2 million to support the operation and funding of elderly persons centres in Ontario. Seniors with special needs were given an additional \$5 million to improve transportation services. We cannot understand why these services may be cut. We certainly paid enough taxes down through the years so that in the twilight years of our lives we would be taken care of to some degree.

Some years ago a poet by the name of James Kearney

wrote a poem that applies to our situation:

God help the poor old pensioner
 our fate is sealed and doomed,
 Constricted by our governments
 as though we were entombed.
 Our tiny little pittance,
 inadequate and small
 Has shrunk and so diminished
 there is nothing left at all.
 While some upon the payroll
 are buying grade A meat,
 The poor old crud on pension
 has pork and beans to eat.
 Our country is a wealthy one,
 the envy of our peers,
 We ride the crest of affluence
 and have for many years.
 But in the meantime tell me please,
 must pensioners give in
 And starve in quiet dignity
 and meet death with a grin?
 We've given of our very best
 and life has passed us by,
 We helped to create a nation
 but now we wonder why.
 They treat us like forgotten souls
 and grind us in the dust,
 Ignoring our predicament.
 is this humane or just?
 But that's okay, you people
 our heads are still held high,
 You'll hear our protestations,
 but you'll never see us cry.
 We know the word is coming soon,
 to stand before the Lord,
 And we the poor old pensioners
 will reap our just reward.

It is time for us folk to unite and join with other seniors' organizations in the fight for fair treatment of seniors and our families, to preserve our rights and the way of life we spent our youth and lives building in this province. Ladies and gentlemen, this is the submission of a Canadian family that goes back many generations, who have done what was necessary for our country. I have served on almost every board and commission in our city and have received recognition for my input in society. I do ask that you give this brief your attention.

Yours truly, Ray Wilson. I thank you very much, ladies and gentlemen.

Mr Chairman, I would like to give the remainder of my time to my co-speaker, Mrs Lesley Penwarden. Thank you very much for your indulgence.

Mrs Lesley Penwarden: Hi. I am Lesley Penwarden. I am here on behalf of the Ontario Network of Injured Workers Groups and the Canadian injured workers' alliance. I would like to thank Mr Ray Wilson for sharing his time with me and giving me this opportunity to speak. You'll have to bear with me. Due to the extreme shortage of time and notice, this is a first draft only; it has not been proofread.

I would like to preface my comments by saying that

never in my own experience nor that of any other individual or organization of my acquaintance have we encountered such an effrontery of blatant contempt for the public's democratic right to fully informed access and participation.

Perusing schedules F, G, H, I and K within Bill 26, which have direct or indirect relevance to the health care system, I was alarmed not only by the content but even more so by the deliberate omission of complete and unsevered references. For example, in schedule F, covering amendments to the Ministry of Health Act, the Public Hospitals Act, the Private Hospitals Act and the Independent Health Facilities Act, I counted 119 severed and/or incomplete references, many of which are actually a sequence of references, making the number of insufficiencies even higher.

It is the standard practice of governments which are proud of their legislation to supply the full wording of clauses changed or referred to in other acts so that the aggregate, integral intention and objective be clear. Why have you not done this? You invite the obvious assumption of a deliberate attempt to obfuscate and prevaricate your true objective.

In part I, Amendments to the Ministry of Health Act, section 8, the Ministry of Health creates an additional and extremely expensive layer of bureaucracy entitled the Health Services Restructuring Commission. Statutes outlining the specific purpose or jurisdiction of the proposed commission are conspicuously missing. The broad scope of subsections 8(6) through 8(8) and "Immunity from liability," subsection 8(9) indicate a large bureaucracy with undefined, unbridled dictatorial powers against which we, the citizens, are to have no recourse. This sort of manoeuvre was found to contravene and not be legally absolute under the Canadian Charter of Rights and Freedoms in 1989.

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Your government was elected to reduce and eliminate bureaucracy, bureaucratic powers and expenses to promote greater freedom from government interference, not increase it.

Elsewhere in the global village and in history, similar legislation can be found in what are recognized as Fascist states and dictatorships.

Amendments to the Public Hospitals Act: Section 2 does not demarcate how "considers it in the public interest" will be determined or construed.

Section 5: "The minister may as a condition of providing...require the recipient of the funds to secure their repayment...." surreptitiously opening the door for profit-oriented hospitals. Under this proposal, in order to secure their operating capital from government funding, hospitals can be forced to hold monetary assets such as cash, accounts receivable and investments, reducing the Ontario Hospital Association to a mere business which must secure loans and therefore be profitable.

The government obviously requires reminding that government money is the citizens' tax money, and we have the right in a democratic society to inform the government how it may spend our money. The present government further requires reminding that it agreed that preservation of the Canadian health care system is

inviolable when it was soliciting votes.

In terms of competing in the global economy, the excellent overall health of the Canadian workforce, combined with relatively low insurance benefit costs to companies, is one of our major assets. Do not destroy this advantage.

The US recognizes and admits that its profiting hospital system, the only one in the civilized world, is also the single most expensive and least efficient health care system on the planet.

Sections 5 and 6 continue to state "that the minister considers in the public interest" without specifying how this is ascertained.

Section 6: the government can demand that a hospital cease functioning arbitrarily. There is no mention of consultation, public hearings, judicial review or other recourse.

Subsection 8(1) creates another layer of expensive bureaucracy, called investigators. There is no mention of qualification or competence standards. There is no mention of the conditions of provocation of a hospital investigation other than "where the Lieutenant Governor in Council considers it in the public interest," which remains undefined. Although untried in the case of a public hospital administration, this may be found to contravene the Canadian Charter of Rights and Freedoms, which protects legal rights. Everyone has the right to be secure against unreasonable search or seizure, not to be arbitrarily detained, not to be subjected to cruel and unusual treatment or punishment etc.

Once more, this government was elected to reduce bureaucracy, bureaucratic power and expense, and accomplish greater freedom from government intervention, not increase it. Borrowing from humour of the macabre, it's déjà vu all over again, folks.

Section 9's replacement produces yet another layer of bureaucracy, to be known as hospital supervisors, to do the work already being done by existing hospital administrations. Top administrators receive some of the highest remuneration in Canada. There's no protection from frivolity and no offered recourse such as public hearings or judicial review.

Numerous sections are devoted to protecting the crown and its employees from liability and preventing legal proceedings for anything done under the auspices of the act. Schedule F alone contains no less than 11 clauses intended to protect this government and its employees from being held responsible for their actions.

Under subclause 32(1)(t)(iv) the government gives itself in effect ownership and total control over our medical records. Amendment 44 gives unlimited, unrestrained dictatorial decision-making powers over hospitals and physicians, without holding hearings.

Amendments to the Private Hospitals Act: In section 15, the licence may be revoked arbitrarily and without prior notice. They may cease operation of a hospital upon receipt of a notice and reduce or terminate amounts payable arbitrarily. There is no entitlement to a hearing or appeal. The ministry may seize total temporary control for a maximum of six months. The ministry may make alterations or repairs when in control and force the closed

private hospital to cover the cost.

Amendments to the Independent Health Facilities Act: The definition of "facility fee" in subsection 1(1) has been changed to allow charging fees for medical services which are no longer covered by OHIP, creating an Americanized, two-tier system.

Subsection 5(1)(a) enables the minister and director to intervene with open market business tender bidding and "send a request for a proposal to one or more specific persons."

Clauses 7(7)(a) and (b), subsection 7(8) and subsection 8(6) further allow billing of patients.

Under subsection 7(10) and clauses 8(8)(a) and (b), the director may demand a facility to cease operating if the director has "reasonable and probable ground to believe." There is no description of "reasonable and probable grounds" and the order is final.

Notice served under sections 18 and 20.1 by a director may now be sent by facsimile or any other paper record and deemed received on the day it is sent.

Sections 18 and 20.1 claim to override the Statutory Powers Procedure Act by denying any form of stay. The only available notice occurs under the new subsection 19(3), with at least six months' notice for arbitrary cancellation of services that are already licensed, but there is no recourse of appeal.

There are no restrictions on a director's ability to change licences other than "reasonable ground to believe" and it takes effect immediately.

Suspicion alone is now just reason for the minister to refuse payment and/or deduct amounts deemed recoverable and ministerial powers may be delegated unrestrictedly. Suspicion alone is just reason for the director to give notice to the registrar regarding an independent health facility.

A new bureaucratic layer of assessors will assess health care at "any reasonable time" by requesting and receiving uninformed consent of the patient to observe their medical procedures.

Failing or succeeding at that, the minister may seize and have ownership control over a patient's personal medical information for purposes "not limited" and for "a prescribed purpose."

A licensee of an independent health facility shall submit information and disclose information to a director, and the information may include personal information. This is assumed to take precedence over acts to the contrary.

Sections 38 and 38.1: two of the numerous sections repeatedly attempting to prevent the public from receiving any recourse or compensation.

Government officials will dictate which physicians an independent health facility may affiliate, with no exceptions.

Paragraph 5.2 of subsection 42(1) requires the licensee to pay the costs of any assessments, inspections or any other "prescribed" circumstance regardless of outcome.

The minister has ownership rights of use over any personal information collected under the auspices of the act and may employ the information unfettered. It further states "prescribing conditions under which persons are

required to submit or disclose information."

Section 42 allows retroactivity of regulations under the act to an unspecified "period before the day it is filed."

Conclusion: This is an unprecedented assault on the rights, freedoms, the very dignity of Canadian citizens residing in Ontario. There are no words to describe a piece of legislation so extremely Fascist in nature. Fascist Germany of the 1930s and 1940s would be proud to call it their own.

Recommendations: (1) In the name of all that is decent, holy, just or whatever turns your ethical crank, scrap Bill 26.

(2) Failing to convince your caucus to scrap Bill 26, vote no.

(3) Finally, you don't have to resign to scare your constituents, family, friends, neighbours and yourself from this horror. Simply cross the House.

The Chair: Thank you very much for your presentations. You have effectively used the time allotted to you. Thank you very much. We appreciate your interest.

1400

CANADIAN MENTAL HEALTH ASSOCIATION, ST CATHARINES AND NIAGARA SOUTH BRANCHES

The Chair: Our next presenters are the Canadian Mental Health Association, represented by Sheila Bristo, the executive director from St Catharines; Linda Hambling, executive director from Niagara South; Corwin Cambray, the president from St Catharines; and Mike McCallion, who's on the board of CMHA Niagara South.

Mr Corwin Cambray: Good afternoon and welcome to the beautiful Niagara region, with its falls, canals, forts, orchards and wineries. We hope you have a chance to look around; some of you are more familiar than others.

My name is Corwin Cambray. I'm the president of the St Catharines and district branch of the Canadian Mental Health Association. With me is Mike McCallion, a member of the board of directors of the Niagara South branch, who will contribute a personal testimony to the importance for people of what you are considering. Certainly I believe that each of you deeply believes in putting people first.

Joining us are our senior staff members: Sheila Bristo and Linda Hambling.

Our two branches cover the Niagara region and its 400,000 people distributed among two dozen communities. We are community-based, non-profit charitable organizations with an active volunteer base of over 120 individuals. We have provided services to individuals with serious mental health problems for over 30 years. Today, we serve 450 consumers who are struggling to develop and maintain meaningful lives in our communities. It is not easy, and it should be not made more difficult. We also provide support to people at risk of having serious mental problems, as well as mental health promotion to the general population.

The number in need is growing as activity in our programs continues to rise. The Niagara District Health Council estimates that there are just over 3,000 residents

in Niagara over the age of 15 who view themselves as limited in their daily functioning because of psychiatric disorders. Approximately 1,500 or more of these residents will seek psychiatric services due to mental health problems. High unemployment and higher proportions of elderly—15% of Niagara's population compared to 11.5% of the population—further point to the need for community mental health services.

I'm now going to turn the next part of the presentation over to Mike before concluding by underlining seven points centred on community and access to public health care.

Mr Mike McCallion: Good afternoon, members of the committee. First, let me briefly describe my position in the community as a means of introduction to this committee. My wife and I have a small business which employs eight people. We face international competition daily and therefore recognize and support both the scope and the urgency of the changes being contemplated by the government of Ontario.

The credential for my appearance before this committee is that I'm a member of the board of directors for the Niagara South branch of the Canadian Mental Health Association. My reason for being a member of the voluntary board of directors is a lifelong involvement, as a family member, with schizophrenia. Possibly this experience will be of some benefit in describing specific areas of our concern to this committee.

My father spent the last eight years of his life in the Hamilton Psychiatric Hospital after being admitted with a diagnosis of schizophrenia. This was during the 1950s, when the only readily available treatment for the medical profession was electroshock therapy. The benefit, if any, from his treatment was limited. My father left the hospital only once during the time he was there.

In the early 1970s, my younger brother developed schizophrenia at the age of 28. He struggled with his disease and, even with the recent availability at that time of new medicines, was only able to function independently for a very brief time. Unfortunately, in the early stages of drug therapy, the medical profession did not fully recognize the incidence of depression among patients undergoing drug therapy. In addition, there was not the same awareness among the patients of the consequence of not taking their medication and they were not comfortable with the side-effects. My brother, during a period of depression, committed suicide.

The reason for describing this situation is to point out both the turmoil and difficulty a person with schizophrenia faces in an uncertain period of treatment. It also points out to society the consequences of not being in a position to provide the required care.

My wife and I have three wonderful children whom we, like the members of this committee who have children, are very proud of. Our youngest is at McMaster University, working through his final year, and intends to continue with his studies in medical research. The middle child is a professional engineer. He works with severely disabled people—quadriplegics. Our oldest child is an outgoing lady with a diagnosis of schizophrenia. I will only refer to my daughter in the third person and not by name, hopefully to prevent any embarrassment to her. My

wife and I are fortunate in that our daughter, after only one crisis subsequent to her initial psychotic episode, learned the necessity for her to take her medicine always. Please bear with me.

The event that led up to her having the second crisis was not the result of any action on her part but was the result of her psychiatrist attempting to change her medicine to allay some of the side-effects of the medicine she was originally prescribed. If you were to meet my daughter, you would notice that she normally stands with her elbows bent in front of her, like this. She is not conscious of this and, if she's reminded, she will put her arms down into a more natural position. However, once her concentration is on other matters, her arms will return to being held in front of her, which is a side-effect of the medicines she takes. Our daughter and family are lucky to have only this minor side-effect as part of our existence. Other patients on drug treatments are faced with terribly discomfiting facial tics, for example, and other involuntary movements associated with tardive dyskinesia. There are other negative side-effects too numerous to describe here. We are fortunate so far, but this could change, and one of the devastating characteristics of tardive dyskinesia is that even when the patient is taken off the drug, the side-effects may continue permanently.

Our family would like to change the drug treatment to one of the newer drugs available which does not appear to have the same propensity for side-effects. Unfortunately, we are inhibited by the one time we did try a change and it failed. However, the crisis might not have developed if our daughter's overworked psychiatrist had not taken a well-deserved vacation during the change. He was one of only two psychiatrists attached to the local hospital. There is now only one psychiatrist at that hospital, and there are only nine psychiatrists in all of the Niagara region—too few.

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Another problem with our daughter changing her medicine is obtaining current medical advice. Our daughter is being attended to by a capable general practitioner, who monitors her blood tests. These tests are made to try and anticipate the effect of the current medicines on her liver and its possible deterioration. Our daughter's general practitioner has neither the background nor the time to keep up to date on the changes in these types of medicines.

As I mentioned, we are fortunate that our daughter approaches her medical regimen with diligence. She is fortunate also in that she has a loving, supportive family to turn to when there is confusion and uncertainty. Many people with psychiatric disabilities are on their own. When they are bothered by side-effects of the medicine they should take or tired of the stigmatism of having to take these kinds of drugs or, even further, when the drugs are working well and they really feel good about themselves, they stop taking the drugs and spiral down into an ever-deepening crisis. Every effort must be made to help these people maintain their medical regimen. Systems should not be set up which will place roadblocks in their way, such as a dispensing fee.

Imagine yourself in this situation. You are living on a

disability pension and your total discretionary spending after accommodations and food is \$30 or \$40 per month. Your medical practitioner is reluctant to prescribe more than a week's requirement of drugs, to help prevent a drug overdose or to prevent the drugs being wasted or misused. So now you are faced with picking up your drugs weekly and facing a \$2 dispensing fee when you do so. This means that 20% to 25% of your discretionary income now has to be used for you to take something you don't want to take. What if you smoked cigarettes and the decision was whether you buy a pack of cigarettes or pay the dispensing fee? If you talk with community support workers, you will find their experience is that people who smoke will buy cigarettes over food. The net effect: more people in crisis, more hospitalizations, continuing high-cost, poor-result treatment.

One of the difficulties our family faced when our daughter survived her initial psychotic crisis was a diminished cognitive ability. We struggled to find an environment where she could function independently in a safe manner. We were hoping to find a program similar to the program available in Hamilton. What we found was an underfunded, frequently overworked staff trying to function without the benefit of support from the medical profession.

We tried avenues which were available, and achieved varying degrees of success. These included halfway housing, secure housing and community programs not specifically designed for people like my daughter. Our daughter has not always found safety through these efforts, but she has been fortunate in having support from the Canadian Mental Health Association staff and from her family. As she tries to fit back into society, her concentration is not sufficient to maintain her education or employment, even though she has tried frequently. However, our daughter is now doing volunteer work with a local food bank twice a week, with the support of CMHA staff. She is making her contribution to society in that manner, and we are very proud of our daughter. She has her family behind her.

There are many people with psychiatric problems who are on their own. Don't put roadblocks in their way. They have enough problems. Don't set up a system which will only focus on crisis management and not provide the community and family support which will reduce high-cost crisis management.

I started this presentation by stating my support for the changes being made, and I recognize the urgency to overcome the lethargy and the self-interest of what is now in place. However, when haste is made, the opportunity for error increases, and the result of error in the area of concern by the Canadian Mental Health Association is tragedy, lost hope and misdirected funding. You have a difficult task. I wish you and yours well.

Mr Cambray: I think Mike's illuminating testimony brings home several points which I would like to underline in our closing part here.

(1) Dispensing fees: A \$2 dispensing fee will not help people. A \$2 fee may seem small to some, no doubt, but not to those of limited means, and it accumulates from week to week. Larger prescriptions are not the answer either because of overuse or misuse. Such types of user

fees have been shown—this goes for user fees much broader—to neither control health care costs nor improve the appropriateness of care.

(2) Drug substitution: Drug substitution is dangerous, as Mike has pointed out, to the health of the consumers we serve. Mike has outlined one example. There are many others. If a physician prescribes a no-substitution drug or the consumer requests a specific drug, it is because that drug has been proven most effective in treatment and the drug should be fully covered under the Ontario drug benefit plan.

(3) Access to specialists: Niagara is underserved by psychiatrists while in certain areas of Ontario there is an oversupply. This imbalance needs to be corrected for, in the end, it is a public health care system. The specialists need to have strong ties with our communities rather than to the Hamilton Psychiatric Hospital, for example. Emphasis should be on treating people with severe mental illness. No family should be told that there are no services for their schizophrenic child while Ontario spends over \$300 million a year for the traditional Freudian psychoanalysis, the most generous coverage in North America to see analysts nearly every day.

(4) Confidentiality: Section 13 of the Ontario Drug Benefit Act may be changed to use or disclose personal information. Our branches as well as the Ontario division of CMHA believe that all medical information should be confidential and private. Psychiatric consumers should not suffer any social stigma as a result of their illness through loss of confidentiality.

(5) General hospitals: Our branches enjoy a good working relationship with the general hospitals in our communities. However, we are concerned that the hospitals will concentrate more and more on core services that could impact negatively on traditional marginalized mental health units by exposing them to severe bed cuts or closures. These facilities in community hospitals are needed to provide emergency backup when cyclical crises occur. On the other hand, the \$385 per day cost to care for individuals in provincial psychiatric hospitals could be much better redeployed to help individuals stay in the community or, when needed, a local hospital.

(6) Funding sources: Many comments have been made about using the existing funding more effectively rather than the need for more funding. Also, there is this shifting of view from a hospital-centred health system—a built bed is a filled bed—to a home- and community-centred system. This will be challenging as we work towards a seamless health care system from the patient's home to community centres and institutions with the focus on primary care in the community. Why then enable hospitals to establish crown foundations to solicit major charitable donations? This situation will reinforce the past and undermine fund-raising activities of community organizations like our branches and even, we believe, the United Ways on whom we depend for needed program funding.

(7) District health council: The health council, or a similar local planning body, should be given the ability to redesign a community-based, integrated health care system in Niagara. Individual institutions cannot do it, nor can a more central body located in Toronto. Dr

Fraser Mustard in 1974 recommended the devolution of funding envelopes to regions. His report established district health councils. It is time to take the next step.

In conclusion, Canada and Ontario enjoy a very good health care system. A 1993 Gallup poll found that 96% of Canadians preferred Canada's system to the one in the United States. That being said, it is acknowledged that our health care system can be made more efficient and effective without reducing and charging for needed services. We know that you will put people first.

1420

Mr Kormos: Thank you, people. I'm from Welland. Stella May Williams was one of my constituents. She had a lengthy history of mental illness and had been treated for a period of time, including numerous hospital stays. She was 48 years old, a loving mother and grandmother, she worked some 10 to 15 hours a week, which was as much as her condition would permit her to, making change in a laundromat for minimum wage.

Three weeks before Christmas she received a letter from the Community and Social Services office in Welland advising her that she was no longer eligible for Family Benefits Act assistance. She was no longer disabled, according to Mike Harris's definition of disability. Three days later she killed herself. Most insulting was, even after her death, a letter was posted to her advising of her right to appeal. She left behind a daughter and two grandchildren, a suicide note that was poignant, indicating that she just couldn't face the future without the prospect of being able to pay her rent and engage in the most modest of gift-giving for her children and grandchildren.

Let me tell you people, Stella May Williams's death is the direct result of Mike Harris and Dave Tsubouchi and their attack on the poor, the sick and the disabled and, by God, I hope she's on your conscience, because her children and two grandchildren have lost a mother and grandmother, our community has lost a just, kind, loving person who was a victim of mental illness and then a victim of government policy that simply doesn't give a damn about the sick and the disabled.

I grieve for Stella May Williams and others who will follow. I hope you have the decency, the respect for the sick and the poor and the disabled, to reflect on the fact that the blood of her death is on your hands because of your support for that outrageous, cruel regime dedicated only to the rich in this province and not to the working people, the sick or the poor. Shame on you. You should be disgusted.

Mr McCallion: Mr Chair, I just have one comment. My daughter's pension was not changed and it was through no effort in our family; it just stayed exactly the same as it was.

Mr Tom Froese (St Catharines-Brock): Thanks for coming. I appreciate your presentation. I don't think anybody in this room would say that the mental health associations and what is in the province and what it has been, people are affected and we would not minimize the whole aspect of the tragedy that's in our province. I for one am familiar—I'm just like you, Mike, as far as having some of these tragedies in my own extended family. My uncle committed suicide as well, some time

ago. So I'm very much aware and very concerned about this issue.

You talked about core services or you talked about the Niagara District Health Council and general hospitals and funding sources and so on. I have two questions. Has the association from the local community, the Niagara district area, made a submission to the Niagara District Health Council to ensure that, when the district health council looks at the whole aspect of the health care in the region, it is core service? The other question is, you've given us some recommendations and I thank you for that. Can you elaborate more on what we as a community can do to assist your association?

Mr Cambray: On the first point, yes, we have. We're in constant contact with the district health council and have made them aware of our concerns, and also the hospitals. The second point, what you can do to help, I think first of all you could support the recommendations that we have in here. I think that's fundamental because we view the foremost importance to be providing the delivery of services to consumers, to the people we serve. The second area—and you did help us there, I must admit; you came to one of our meetings and made a presentation. I think just the awareness and constant contact on mental health issues, which is a very difficult issue to deal with, is very important.

Mrs Lyn McLeod (Fort William): I'd like to bring us back to Bill 26, Mr Chairman, a bill which this government intends to make law in nine days. I want to thank you for your presentation of the concerns that you have about Bill 26, particularly the effects that this bill will have on psychiatric patients and those suffering from psychiatric illnesses. Those effects will be real unless this government changes this act. It doesn't matter what statements of concern the government members make, they have to change the act to prevent those negative effects that you've outlined from taking place. That's what this is all about.

I'd like to ask you specifically about confidentiality, because you've just touched on it in your brief, and your concern that this bill would give government bureaucrats and in fact politicians access to medical records and an ability to disclose the most confidential information about patients, including psychiatric patients.

When others have presented this concern, one of the members opposite indicated that people shouldn't be concerned because the Mental Health Act would supersede Bill 26. We challenged that and today we received an answer that indeed the Mental Health Act would only protect the confidentiality of patients who are in psychiatric institutions.

I'm wondering how you feel about there being two classes of psychiatric patients: those who have their confidentiality protected in some way and those who can have their records examined, copied and disclosed with no penalty for misuse of the information.

Mr Cambray: We are concerned. As I said to the previous one, first of all, we have recommended making these changes. We realize the legislation has been changed. The second point, we are concerned that confidentiality is a big issue. Our Ontario division, which

has more resources to look into that, is concerned.

Two levels: We don't see that at all. We deal with consumers in the community. They're not in the hospital, they're out in the community, and the intent is to try to get more and more people out in the community, so it must be confidential. People we serve face enough stigmatism without having their records appear all over the place.

The Chair: Thank you for your presentation, Mr Cambray. We do appreciate your interest.

The next presenter is Angela Browne, the executive director of the Niagara Mental Health Survivors Network.

Mrs Caplan: While we're waiting, can I put a question, Mr Chairman?

The Chair: Just let me call her one more time in case. Is Angela Browne in the audience? Okay, Ms Caplan.

1430

Mrs Caplan: This morning I asked a question in relation to the provisions of the Mental Health Act and confidentiality and asked for certain clarifications. There is a policy issue that was just raised by our leader, Mrs McLeod, and I'd ask this to be answered by the minister. That is, how can he justify two classes of mental health patients in this province, one that has the special protections afforded under the Mental Health Act and those who will be impacted only by the provisions of Bill 26? How can he justify, by policy, the fact that under the Mental Health Act only some patients with psychiatric requirements, psychiatric needs, will have access to those confidentiality provisions while other patients in the community and in community hospitals may not have those same protections? What is the policy that would justify patients with similar or totally different mental health problems being treated so differently? Could the minister answer that question in writing.

The Chair: Thank you, Mrs Caplan. Is the Niagara South Social Safety Network, Mary Beth Anger, here? The St Catharines Labour Council? The St Catharines Labour Council is ready to go but they need about three minutes. So we'll just take a quick three-minute recess.

The committee recessed from 1432 to 1435.

ST CATHARINES LABOUR COUNCIL CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 1097

The Chair: Okay, our presenters are ready, if we can take our seats again, please. From the St Catharines Labour Council, Allison Williamson and Gabe MacNally. Welcome to our committee. Questions during your half-hour would begin with the government, if you allow time for them. The floor is yours.

Mrs Allison Williamson: My name is Allison Williamson. I'm president of Local 1097 of the Canadian Union of Public Employees and a member of the St Catharines Labour Council. I would like to thank you for the opportunity to present this brief to you today on behalf of the St Catharines Labour Council and of the Canadian Union of Public Employees.

Before I start, I would like to say to you that I represent what the government refers to as a special-interest group. I am a consumer, a taxpayer, a mother, a provider

of health care as an RPN for 35 years, and of course a trade unionist. I make no apology for who or what I am.

This bill attacks me and people like me on every front. It is unparalleled in its contempt for the average citizen. As far as I am concerned, the real "special interests" being promoted by this bill are not for people like me, the average citizen.

As the hearings draw to a close, you will have become acutely aware of the strong objections to every clause of every amendment of the 47 acts dealt with in Bill 26. I am also sure that those who have come forth to support the bill are the rich or those who will reap personal gain or power through the proposed changes.

This bill and the method chosen to try to pass it without any consultation or debate are without a doubt the most undemocratic venture we have ever seen or will see in the future of this province.

Most of the electorate who voted for you, with or without reservation, based on your Common Sense Revolution platform, placed their X based on the promise made by Mr Harris that if health care was cut, he would resign. This gave us a false sense of security, thinking that health care was sacred and would escape cuts. We all know that Mr Harris should have resigned before he introduced Bill 26 if he was a man of his word. He broke his promise when he cut funding in November 1995. I feel confident that should an election be called tomorrow, the results would paint a very different picture.

Virtually every clause that pertains to health care in Bill 26 is aimed at dismantling our system. Clearly, government is trying to fashion a "made in the USA" health care system for the people of this province, a system that delivers one level of care for the rich and a different level for the rest of us.

Bill 26 will give the Minister of Health virtually unlimited powers with respect to funding and operation of public hospitals. It will allow the minister to ignore the needs and desires of the local communities. The minister can decide that the availability of financial resources is the only relevant criterion when making funding decisions. The minister has the unlimited authority to close hospitals, force mergers, and order hospitals to change or eliminate types of services that will be delivered. Since the government is saying that 33 hospitals should be closed in Ontario, the bill will provide it with the necessary mechanism to achieve this goal quickly and aggressively. No public consultation will be necessary on even the most superficial basis.

Bill 26 also provides tremendous levels of liability protection to the government during the restructuring procedures. They cannot be sued or held accountable for virtually any action they take under the authority of the new legislation. The Ministry of Health will become a dictatorship, and the citizens of Ontario will have no recourse to protection from the damage that will be inflicted on them by the Harris government.

1440

We in the Niagara area are a have-not community; we have not adequate funding in every aspect of health care. In order for hospitals to balance budgets, they've had to close beds and curtail services, limiting the number of inpatient beds. Surgical procedures are now being

delayed, as beds and operating time are unavailable. Medically ill and accident victims are held in emergency rooms on stretchers awaiting discharge of inpatients occupying those beds. This increased pressure for bed spaces forces the doctors to discharge patients earlier than they believe medically advisable. Consequently, patients are forced to return when they experience a relapse. Unfortunately, it is difficult to keep statistics on readmissions, as these patients do not always return to the same facility.

If Bill 26 passes, those requiring hospital beds will wait longer, become more acutely ill, and take longer to recover, which will increase costs instead of decreasing costs. As a result of these occurrences, people will die unnecessarily.

The hospitals at present in the Niagara area have limited paediatric services. The St Catharines General has no paediatric intensive care unit. Therefore, if children require that level of care, a makeshift intensive care unit is set up in the child/adolescent unit. In Niagara Falls and Welland, they place these children requiring intensive care into the adult intensive care unit. Only Niagara Falls and St Catharines General have neo-natal intensive care units. Those children who require care and treatment beyond the technology and specialties of our paediatricians are taken by ambulance to a helicopter pad and flown to either Toronto, Hamilton or London. The bill calls for amalgamation and reduction. I would ask you, move what to where?

The statistical comparison by the OHA—this is not in my brief, by the way—that shows the dollars per capita spent on hospital funding indicates to us that we here in the Niagara area are funded at approximately 38% below the provincial average. I ask you, do you want to take more from us? We're not getting our fair share now.

Despite the dense seniors population within the Niagara region, one of the highest in the province, we have no clinics that specialize in geriatrics. You cannot even find a gerontologist listed in the current telephone directory. Our facilities have already closed chronic care beds, and long-term-care patients are now occupying the active medical-surgical beds. The senior citizens' homes have already had funding cuts. Those requiring placement in these facilities are closer to being classified as chronic rather than those who require the care at the placement level provided in a nursing home and homes for the aged. With fewer staff available, the level of care is decreasing. Who suffers?

It is clear that every cut has a direct impact on the quality of care for the residents. Our seniors are the citizens who fought for and won quality health care for all of us. That includes Mr Harris. Bill 26 will deprive them of their deserved rights, their dignity and self-worth in their twilight years.

I would like to have been able to provide to you at this time a brief that is being prepared by the municipal government here on chronic care and long-term-care facilities. Unfortunately, it's not ready right now, but this will contain the current number of beds in the system and those on the waiting list. This report will be available tomorrow and I would ask that I could forward it to you

to be accepted as part of my brief.

The figures that I do have at hand right now are that in the Niagara area, the totally funded beds for the chronically ill and long-term are 2,921; the waiting list as of December 31 was 1,029. So we actually have at least one and a half people for every bed that we have. Those are the current figures. Accurate ones will be out on Friday.

Bill 26 provides explicit authority to allow the cabinet to make regulations that could increase user fees. This will open the door for hospitals to charge for even the most basic elements provided now, like linen, food and rooms. The worst example of user fees that could happen has already been announced. Hospitals will have the right to charge a daily user fee to those patients in acute care beds who are awaiting placement in chronic care facilities or nursing homes. In the Niagara area—and I've told you already what the waiting list is. Where does the government expect these people to get the money to pay for this? From their spouse who is already on a fixed income or their family who are probably already overburdened financially? Or from a different purse of the government? If you can't pay, what then?

Bill 26 proposes to change the Health Insurance Act. These changes would give the cabinet the right to decide which services are insured and under what limitations and conditions, most likely limiting access to services now provided. By removing the phrase, "medically necessary," the criteria for coverage will probably be cost. We all know what this would mean: the ability to pay. So if you are rich, the medical treatment will be there and if you are poor, medical treatment will not be available.

Bill 26, F and H, opens the doors for the Minister of Health to collect, use or disclose personal medical information in the name of effective management. Confidential medical information will become a thing of the past. Those who are most vulnerable in society, namely, the senior citizens, the mentally and physically challenged, the chronically ill and the poor, will find themselves deprived of the necessary level of care because the government deems them to be abusers of the system. The bottom line is economics, not the necessity for medically necessary medical care and treatment.

It is difficult economic times that historically reflect the physical and mental wellbeing of the people affected by unfair economic and political agendas that blatantly target the poor. Consequently, unnecessary pain, suffering and death will occur. This is an onslaught on the principles of the Canada Health Act that we cherish, which has provided all Canadians with quality health care since its inception.

Bill 26 also provides changes to the Ontario drug benefit plan. If schedule G is passed, the bill will put a two-tier health system in place. User fees for prescription drugs could be introduced along with the proposed \$100 deductible. For the poor this would mean prescriptions will not get filled because they cannot afford them. Once again, the hardest hit would be the senior citizens, the disabled and the poor.

It has been suggested that we shop around. Locally the cost of filling a prescription is \$10.50 at the top and \$3.99 at the bottom. The unfortunate reality of this

suggestion is that seniors, the disabled and the poor would have little access to the low \$3.99 because the particular drugstore does not deliver. The public transportation in Niagara is inadequate and, generally speaking, these citizens have no transportation of their own. Marketplace competition and profit-making have no place in the provision of health care.

In conclusion, this bill is a disaster for the health care system and catastrophic for the people of the Niagara area. Major restructuring of health services was done in St Catharines in the 1970s. We are already cut. We have the second-highest unemployment rate, 9.3%, of any metropolitan centre in this province, only a hair behind Sudbury at 9.4%. In addition, there is a very high population of people over 60, almost 21%.

All of these factors mean that more and better health care and long-term care services are urgently needed. But much less and worse is what we are going to end up with if this bill goes through. I am here to tell you today that the people of the Niagara area will not settle for less or worse health care. We will not accept being lied to by the government that has done a complete about-face on its health care pledges. We have fought back major attacks on our health care system before and won. If you are determined to push this bill through, we are as equally determined to stop you.

1450

Mr Gabe MacNally: If I may supplement Allison's presentation, I have with me a petition which was drafted by a group of members of our union, young workers whose plant just closed and is moving to Magog in Quebec. Being more concerned about the attacks on seniors in this province than the loss of their own jobs, they took the time to circulate this petition and came up with approximately 300 signatures. I was asked to pass it on to Peter Kormos so he could present it in the Legislature to the Premier.

Mr Hudak: Thank you for the presentation today. When you talk about lack of paediatric care, when you talk about long waiting lists for nursing homes—and the group before you pointed out the lack of psychiatrists in the area—you very clearly point out that the status quo is not working.

This government was elected to change the status quo, to do better with less, so we can reinvest that money in essential services like paediatric care or more psychiatrists for the area. I know, representing the southernmost portion of the Niagara Peninsula, that we need more GPs in the area.

At the same time as you recognized that the status quo doesn't work, obviously you have a lot of reservations about Bill 26. My question to you then is, what suggestions do you have for this government to do better with less so we can make the savings in the health care system and invest them into the areas where we really need the money in health care again?

Mr MacNally: I guess that's a philosophical question, whether you believe we have to do better with less. I don't know of anybody who has been able to do better with less, and I guess there are a lot of welfare recipients out there who will attest to that. The question is, is the present tax system that we have in this place in this

province and this country working? I would suggest it isn't and I would suggest we can maintain our current level of social programs if you address the root of the problem prior to making any changes to any of the current social programs we do have. You asked for an answer; I gave you an answer.

Mr Hudak: Aside from raising taxes, which was tried—what?—32 times with the previous government and 33 before that—

Mr MacNally: I didn't say raise taxes, Mr Hudak.

Mr Hudak: I was speaking to the nurses today, just outside in the hallway, and they told me how there is a lot of duplication in this system. I agree completely that they should have a lot more say in where savings could be made. They would disagree. They would say there are savings to be made that could be put back into the system. Mental health made an excellent presentation. But I appreciate your point on taxes. I disagree. I think a lot of people in Ontario, the taxpayers, would disagree with that as well.

I wanted to get to the point also about GPs. For five years there's been an agreement between the OMA and the government to try to get more into this area. As a representative for the southernmost portion of the riding, the southern portion of the Falls and Fort Erie and Port Colborne and Wainfleet, I'm very concerned about the lack of GPs in that area. It has been suggested that the minister limit billing numbers to areas that are underserved, in other words, to get doctors out of Toronto and into areas like Niagara South.

Do you agree with that suggestion of limiting billing numbers to where they're really needed or do you have some other idea on how to get GPs into underserved areas like Niagara South?

Mrs Williamson: I wouldn't want to speak on behalf of the doctors, but I will say, if the facilities for them to take care of their patients were in place in the Niagara area, they would be here. They come here, they have their patients—because I refuse to use the word “clients”—to take care of and no place to take care of them. They have to send them out of our community to Toronto, Hamilton, London or somewhere else, because we don't have the facilities here for them to take care of them.

I believe that's probably why we don't have enough physicians here, because even if they're here, they have to send outside, they are being used as a referral centre to get help somewhere else. We need the services here in the Niagara area. The doctors will come if it's here for them to be able to carry on their business. That's my personal belief.

Mr Bradley: An excellent brief presented to the committee. I want to deal with a couple of spinoffs from the brief and from other briefs today and get the reaction of the St Catharines Labour Council. This morning representatives of Liberty Health, who in effect are the successors to Blue Cross, indicated that, as a result of Bill 26, one of the implications could be that drug pricing would go up to such an extent that it would discourage companies from becoming involved in early retirement packages.

In the Niagara region we have had several companies

either downsize significantly or close. General Motors, with the foundry closing, is one example of where early retirements have been used to good effect. What would be the impact on the workforce in this area if General Motors and other companies did not utilize the option of early retirement to address its problems of layoffs?

Mr MacNally: If we hadn't been able to negotiate that agreement, we probably now would have had people on layoff not just collecting UI and SUB benefits but also knocking on the door of the social assistance people for social assistance. We have had some members on layoff since 1992. We have been fortunate enough to keep those numbers low by negotiating an early retirement package.

In response to what increased drug prices would do for the future, it's certainly going to put a heavier burden on employers in regard to either paying those premiums or their employees, and thus we're going to be faced with a choice. Do we tell a corporation for which we represent workers to pay those extra premiums and maintain the current level of health benefits and take a lesser increase or a decrease in wages to do that and thus have a trickle-down negative impact on the economy because of that?

Mr Bradley: Would you anticipate that you would see on behalf of employers attempts, because of their increase, to begin contract-stripping in the field of health care extended benefits?

Mr MacNally: Not only that, Mr Bradley. I come from the auto sector and it's no secret that we have a cost advantage over our US counterparts of approximately \$3 to \$4 an hour because of the Canada Health Act and the current health benefits within our country versus the private enterprise in the US. That gives us a competitive edge, so to speak. Without that competitive edge, certainly we would see many of our jobs disappear to the US southern states, Mexico or other countries, and the unemployment level would increase.

Mr Kormos: Sister Williamson, Brother MacNally, welcome. There, I've said it. I can hear the Tory wheels turning. “Look, Kormos is in bed with labour.” Let me put it this way: I feel entirely comfortable in bed with labour. It beats the hell out of being in the back pocket of corporate Bay Street.

I've got a copy of a letter here from a Fonhill doctor to his patients. It's called a “Billing Notice, 1996,” annual fee \$50 per patient. This doctor is requiring each and every one of his patients to pay an upfront \$50 fee to be that doctor's patient. That's cash on the barrel head in exchange—it's sort of like joining a record club, I suppose, because in exchange for paying that upfront \$50 fee he makes a commitment to giving discounts on the fees for unlisted services.

I think we should review some of the fees that are being charged currently, clearly: “telephone renewal of prescriptions, \$15; telephone advice, \$15; in-office injections”—I presume if you have to get injected with something or other—“\$5 to \$10 per injection; pre-employment physical, \$75.” How does an unemployed person who has no income, who wants to get a job, cough up \$75 cash on the dash for a doctor if that physical is necessary to get that job?

“Canada Pension Plan disability medical report”—

again we're talking about a person with no job, they can't work; they're applying for the Canada pension plan disability—" \$60. Electrocoagulation of benign lesions, \$15 a lesion."

1500

Unfortunately, Bill 26 is going to enhance this level of user fee. Bill 26 is going to create, very clearly, two types of medical care for people here in the province of Ontario: one for the rich, one for the poor. This government is more and more interested in privatization of health care services, has no commitment to the Canada health plan, has no interest in providing universal accessibility to health care and indeed envisions an American-style health care system here in Ontario. This government will make Ontario the Mississippi of the north when it comes to health care.

How are poor people, how are unemployed people, how are seniors on very fixed, limited incomes supposed to be able to pay these fees and other user fees? And how does Mike Harris get away with calling them copayments when they're in fact user fees, and when he lied to the people of Ontario when he promised no user fees but in fact introduces user fees under the guise of copayments? Can you differentiate between copayments and user fees?

Mr MacNally: No, I really can't. I think they're one and the same, but you ask specific questions. I think they should be referred to the members of the government so they can answer those, because within Bill 26 there are very few answers to many of the concerns that we have as residents of this province.

Mr Kormos: Unfortunately, Bill 26 was developed in such secrecy that even the government caucus wasn't aware of its contents, even the cabinet didn't have an opportunity to see all 17 schedules to it presented in one form. It was leaked out a bit at a time to cabinet. Caucus members were shocked and surprised that the bill indeed had been tabled, read for first reading. In fact, the ministers of this government have been miserably incapable of explaining the contents of Bill 26. Al Leach clearly didn't understand what Bill 26 meant to the areas regarding municipalities and taxation powers of municipalities. The Minister of Health—we've seen this incredible back-peddalling on the part of the Tories, this effort to clean up, to spin-doctor. They've spent a whole lot of taxpayers' money introducing their no-name little bit of propaganda, which is a shameful bit of hack crap.

The Chair: Thank you very much, folks. We appreciate your presentation here today.

Mrs Papatello: Mr Chair, I need to table a question.

The Chair: Can I call the next presenters forward first so they can come forward? From the Niagara Mental Health Survivors, Angela Browne and Joseph Biller.

Mrs Papatello: My question's for the Minister of Health, and I think it's appropriate that we get the answer as quickly as we can. Daily as we've gone to town after town, the Conservative members sitting around this committee have continued to imply and ask questions of those who are presenting, intimating to them that somehow their town or region is now going to be assessed as an underserved area and that after the passing of the bill, suddenly we're going to have this even distribution of doctors. When has Niagara ever been classified as

underserved? It never has.

For the members sitting here today to suggest that all of these savings will now be redistributed—

The Chair: Is there a question here?

Mrs Papatello: Absolutely there's a question. It is absolutely false to suggest that after this bill, Niagara region will be considered underserved. That is misrepresentation on their part. If the Minister of Health knows which areas will be classified as underserved, we in Windsor and any area in Ontario which is non-teaching are desperate to know that they too would be classified as an underserved area. It is misrepresentation on his part—

The Chair: Put the question, please.

Mrs Papatello: —and we all resent it highly. We need to know immediately which areas of Ontario will be classified as underserved and we need to know right away, because otherwise every member on this committee has been blatantly misrepresenting themselves, every one of us.

The Chair: Thank you, Ms Papatello.

Mrs Papatello: Do you have any idea if that's what is happening in this area?

NIAGARA MENTAL HEALTH SURVIVORS NETWORK

The Chair: Welcome to our committee. We appreciate your being here. You've got a half-hour to use. Questions, should you allow the opportunity for them, would begin with the Liberals. The floor is yours.

Ms Angela Browne: Hello, folks. The Niagara Mental Health Survivors Network, hereinafter referred to as the Network, is an incorporated self-help and economic development organization for individuals who receive treatment for mental health problems, whom we're referring to in this paper as mental health survivors.

I didn't really have a terrible lot of time to go through Bill 26. I just took some of the fine points and I also distributed to you A Common Sense Approach to Mental Health Reform, which is one of our consultation papers we had with our membership a few months ago before I made a presentation to the Clarke Institute of Psychiatry and the Canadian Federation of Mental Health Nurses.

With approximately 100 general and associate members throughout the Niagara region, the Network has established its priority interests as (1) employment-economic development; (2) skills-knowledge development, research; and (3) advocacy. Throughout the past year and a half, we published several reports, including On Our Way to Work: Removing the Barriers to Economic Dignity, our report to the standing committee on human resources development on social security reform, A Common Sense Approach to Mental Health Reform, which you've all got in your hands, and we'll soon have available an information and advocacy booklet for survivors.

We've also produced numerous position papers on issues ranging from mental health reform, systemic advocacy, definition of disability, guaranteed support program for the disabled to community economic development. We try to take a realistic approach to things, particularly

as we understand that we are dealing with fiscal limitations, but we still at the same time need to have a balance with human services.

In general, as an organization, we do support the concept of greater fiscal program accountability, cost-effectiveness and open democratic processes. For this reason, we appreciate being given an opportunity to speak on Bill 26.

The concepts of accountability, cost-effectiveness and open, democratic principles are issues that most of us can embrace, regardless of where we come from on the political spectrum, particularly as programs with good to excellent outcomes should be rewarded and less effective programs get penalized. The emphasis is on performance, effectiveness and value for dollar, which is crucial for the delivery of services, particularly if you hope it would lead to better programs. We really need to look at that before we consider taking something wholesale and just cutting it.

Henceforth, we recognize that more spending in any area does not necessarily lead to a healthier population, nor does it necessarily provide long-term stimulation for the economy. However, we do believe there is a role for government in reducing and ameliorating the pain, suffering and economic loss associated with long-term social disadvantages, including mental health problems and other disabilities.

We do believe there is an association between increased use of mental health services and lack of access to meaningful jobs and a decent income for the majority of mental health survivors. We do believe that reinvestment into proven community-based and preventive approaches would not only save us money, but keep us healthier in the long run. Healthy populations do not use hospitals as much and mental health survivors who have decent access to employment and community-based supports do not require as many costly services. These are the things that do save money.

With any changes to health care or related social services, it is organizations like ours that are a barometer to the effects felt by people at the street level. It is organizations like ours that receive the telephone calls, referrals and crisis visits by individuals who are genuinely afraid of how they are going to live next month, whether or not they are going to eat, let alone maintain a roof over their heads. In the past two months, we have encountered three separate incidents in which survivors have taken their own lives. In one particular case, the person stopped by our office to discuss what appeared to be a no-win situation related to general welfare assistance. We tried to do what we could for her, but a week later she said that she told her family goodbye and she told her boss that she would not be back—she was working part-time—and told me that I had done all I could. A week later she took her own life.

1510

While we recognize these deaths do have other factors in their causation, our experience suggests that a procrustean-bed approach to belt tightening does leave many people quite vulnerable. This person is a different case from the case that was mentioned about Miss Stella Williams; this is a different person. The cases are remark-

ably similar, and I am just trying to study some of the backgrounds in them before I can really get into specific comments or research on it.

I have specific comments on Bill 26. I try to go through each of the schedules one by one and pick out the stuff we have had concerns about.

Health services restructuring; amendments to the Ministry of Health Act:

The Ontario Council of Health, under section 8 of the act, is replaced by a Health Services Restructuring Commission, which is a corporation without share capital and is given authority to carry out any duties assigned to it under the Ministry of Health Act or any other acts. The range of authority or limitations given to this new commission is neither clear, nor does there appear to be a consultative process included in any of the decisions that can or will ultimately be made by the commission.

The government seems to be willing to amend the bill to include the role of district health councils, perhaps as the regional bodies to make recommendations to such a commission, and while we do cautiously support such a move, we anticipate the government would also be reviewing the structures, appointments processes and operating guidelines of district health councils to ensure there is appropriate community and sectoral representation on all DHCs. As this role would give the DHCs increased influence over regional health matters, it is crucial to ensure that those appointed to such bodies, or any of the other subcommittees of the DHCs, have at least minimum qualification and no conflicts of interest with respect to their own affiliations with any ministry-funded programs.

Our companion document entitled *A Common Sense Approach to Mental Health Reform* details some of the issues that must be dealt with prior to releasing any new mental health dollars—and there should be new mental health dollars. I don't think we should be cutting in this vital area, because there is a need for the services—maybe redirected or reshifted or rethought, but not cut at all.

Please note another one of our recommendations stems from the composition of the health structuring commission. This commission must include regional, sectoral and other interests—for example, consumers. However, we would recommend that no member of the commission be part of any local district health council or ministry-funded programs. This will give health proposals another set of eyes with the potential to be objective and free of conflicts of interest.

Amendments to the Public Hospitals Act:

Proposed sections 5 and 6 give the minister broad powers to close or amalgamate hospitals, reduce volume or stop providing certain services, or provide or increase certain services if the minister considers this direction to be in the public interest.

While we have no problem with the fact that hospital services do need to be operated more efficiently, with more dollars flowing to community-based services and programs, it is not clear which circumstances constitute a "public interest," other than a vague reference to the quality of management and administration of a hospital, the quality of care and treatment of patients in a hospital,

the proper management of the health care system in general and the availability of financial resources for the management of the health care system and for the delivery of health care services.

First, it is not clear how this is determined or how it is adjudicated. We would like to see the formation of a board or a special panel to which the investigators report, with some composition that includes members of the public, consumers and others, including those with an expertise in management and also an expertise in the health care sector in the community. Then this board or panel can make a recommendation to the minister.

Secondly, it is unclear who the investigators are. Is there a possibility that you might want to rejig this, to rethink this and make it into something where we can have quality control panels go out, with representatives of the public examining the way hospitals are and to make sure that, if a hospital is well functioning, if it does serve the community properly, it is not going to be put on the cutting block, to protect some of the needed services? But if it is not functioning properly, either get it functioning properly or use some of the provisions of the bill.

These investigators must be able to carry out inspections without prior notice, particularly in the event of a complaint. This will allow members of the public to have more input in decisions about the future of hospitals in their area while avoiding vested interests.

As major psychiatric facilities are not covered under the Public Hospitals Act, we would suggest these conditions also apply to these facilities. It is important to note that patient care in many psychiatric hospitals remains poor, due to lack of informed consent, frequent or inappropriate use of restraints, overmedication and poor discharge planning. Putting psychiatric hospitals at risk for closure as a result of poor patient care might encourage these facilities to develop proper guidelines for patient care and enforce them if they wish to continue operating.

But as I'm going to say later on, I don't think we should start considering closing psychiatric beds before you have the dollars there in the community. If you start closing psychiatric beds down and there are no community services, we're going to end up with people overloading and overflowing on all the other social services. It increases the demand, and I don't see where the cost savings would actually be realized, given the possibility of other health problems and also the possibility of perhaps petty crimes or other kinds of incidents that actually would increase your costs.

Amendments to the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act: Eligible persons under the act will bear part of the cost for prescription drugs. The amount will be prescribed by regulations. It was proposed that a \$2 charge be levied on all prescriptions issued under the act to eligible persons, including those receiving general welfare. The very reason many people are on welfare to begin with is poor health. For many, they must take medication.

We are concerned these costs are borne disproportionately by the poor: \$2 for a wealthy senior is coffee money, while \$2 for a person on welfare is dinner. When

faced with the choice of paying for groceries or medication, what do you think they will take? They will take the groceries first. Many survivors will opt to stop taking their medications, which will result in increased hospitalization, which will wipe out any cost savings from the decreased support on the Ontario drug benefit.

The recent proposal to allow pharmacists to waive the aforementioned fees may do well where there may be competition among many pharmacies in urban centres. However, mental health survivors living in small towns or rural areas may not be able to find a pharmacist willing to waive the fee. This will be difficult, particularly close to the end of a month.

Privacy and disclosure of medical records: We consider the medical file to be the property of the individual and their doctor and nothing else. This is a personal record of yours, it's personal information, and it should not be disclosed to anybody without that person's consent. The right for an individual to review, copy and/or object to contents in their own medical file must be preserved, while the confidentiality of such a file must be protected from third-party interests.

We do not feel comfortable with the minister and/or his official staff having access to our personal medical records. People with psychiatric or other similar types of disabilities feel there need to be some guarantees of confidentiality, particularly if it is in their interests to proceed with their therapy. Otherwise, people will drop out. Many people will be reluctant to seek medical care for conditions like AIDS for fear of disclosure to an employer or to an insurance company or other ministries. They may be reluctant to seek care when treatment is possible, or much cheaper to carry out.

We see no reason for ministry officials to have access to our private medical files. If this measure is implemented for the purposes of fraud, is it really necessary to include patient names and identifying factors? Why not remove all the identifying factors on these medical files and assign a number and maybe even a code for each of the services that were performed, without going into a lot of details about the person? There are lots of ways that these things can be done and put together so you can still investigate fraud or if something has been mishandled or something.

A better idea also would be to set up a pay scale that reduces incentives for physician fraud, for example, putting them on salaries. I admire that Mr Wilson is looking at some of these options, but I think they should continue to look at these options. This is necessary, to start looking at different billing practices of physicians, and also possibly put some limitations on the annual billings for tests and other matters, of course keeping it flexible in certain circumstances, or if you have a lot of patients with particular conditions or something. The amount of this restriction could be negotiated with the physicians' association. Then they would allow the physician to decide about tests within the new prescribed limitations. That way, you're not going to get into a person's personal medical files, you'd be clearly investigating for any misappropriation in billings or whatever you're looking for, without having to get into people's personal history.

Amendments to the Health Insurance Act and the Health Care Accessibility Act: The bill authorizes the minister or cabinet to make decisions about what medical services to insure and for whom and how to insure them. The proposed subsections 11(4) and 11(5) of the Health Insurance Act authorize age to be used a criterion for the definition of "insured services." It is discriminatory to deny essential health services to seniors, and it may be subject to a charter challenge.

You may be familiar with the Roberts case, where a senior citizen was granted visual technical aids as a result of a visual impairment and he was denied it because it was only available to certain people within a certain age group and he wasn't using it for work. So he took it and he won the case at the Ontario Court of Appeal to say that was something that he was entitled to regardless of his age.

This is a problem when you start classifying age groups, disability types, severity of disability. They would all be subject to charter challenge or a judicial review, and it can be a problem where the government may be facing legal bills that it may not be eager to pay for. There has already been that ruling, as I said, and there are other rulings too that were done before that.

This wide discretion may also be problematic in that under the proposed subsection 18(2) the ministry may refuse to insure services that are not deemed to be medically or therapeutically necessary. Who is going to determine this? Are they a group of doctors, and do they know this patient? I have a real problem when someone else is going to decide what services are not necessary and they're not medical personnel and they're not somebody who has the background or skills to even know what types of tests and so forth would be necessary in any given circumstance.

Also, how is this determined? Does this mean people with multiple handicaps that cannot be cured but maybe treatment might just make them feel better, or perhaps people who are terminally ill can be denied treatment on the basis of if it was given to them, it would not be viewed as helpful? If somebody's dying of AIDS or dying of cancer, would palliative care services be denied because this individual is not going to get better? What tests will be deemed necessary and what tests will be deemed unnecessary?

These are all questions that are going to be reviewed, and how are you going to apply them in each individual case? I don't think the government of the day has the time to do that, personally. I think you have to leave it up to your family physician. What you need and your services are between yourself and your family physician.

Under another proposed section of the Health Care Accessibility Act, subsection 2(3), hospitals may be permitted by regulation to charge patients for insured services, such as medications prescribed during a hospital stay, meals, therapy and other services. This has the potential to create a big barrier to access to care, as health problems will not go away because they get defunded. They may end up costing more in the long run as the patient is sent to emergency services or admitted to hospital for a longer period of time.

The next part is cost-effective use of health care

resources. Several studies have shown that user fees of any kind in the health care system deter people of lesser means from accessing the care they need when a condition is still in its early stages. We do not support the introduction of user fees of any kind in our health care system, because people simply cannot afford it. Most people who are mental health survivors are out of work. They don't have the money to pay extra for prescriptions or for extra services they might need. It's bad enough sometimes to have to travel to outside areas to get the care they need, and sometimes this even presents a hardship. And I think we really need to know who we're talking about and who we're trying to work with.

However, as our concerns primarily lie in the area of mental health, we did not see many references to mental health care specifically in the bill. We would assume the Health Services Restructuring Commission would work with the local district health councils in making recommendations to the minister. But there was really no indication of where this fits in or what structure you're recommending this to be. We would also presume this commission will also deal with mental health programs.

Our concern about hospitals closing is that many psychiatric beds will be lost with the \$1.3-billion cutback. We are concerned that care must be taken to ensure that dollars flow from the institutions into comprehensive, community-based mental health programs prior to approving any bed cuts in any hospitals. This is very crucial, because when you're leaving people without care in the community, they're going to be putting a lot of pressure on other services, and it's not going to save money, because people need to have something there in the community for them.

Second, we are concerned that the community-based mental health sector should be more accountable and a greater percentage of its funding must be tied to acceptable outcomes. For example, there should be an evaluation process, an external evaluation process, placed on all the different mental health programs. We want to make sure that they're effective, that they're doing the job they're supposed to do and that the people who are using the services are benefiting. It's not enough to say that someone likes the program to consider that to be effective. They have to benefit from it. They have to show that they are coming along in their problems and their recovery. They have to show that they are able to go back to work, or live on their own, or whatever the goals are that were set with their therapy. It's very important to have program evaluation from external evaluators with the proper skills in order to do it.

For example, many of these mental health programs do not have a clear statement of purpose, goals or objectives. Some people are there forever and they never get a discharge from the program. I think there should be some kind of way where there is a link between these programs and then the person in the community so that they cease to become just consumers of mental health services and become citizens. There has to be a stage between one to the next stage. You can't just have somebody that, just because the program is there, they can go there every day for the rest of their lives. We don't particularly consider

that to be helpful.

If an agency is supposed to help survivors find work, for example, I think we have a right to know how many survivors actually got jobs out of it. If an agency is trying to get into crisis management, if you're in a hospital situation or outside a hospital setting, we want to know how many people were averted from going into the hospital, and therefore we can probably realize what cost savings we actually have.

Also, we want to know what people want. There is a very high demand for employment services. When mental health reform was put into place, employment was given the back burner. Nobody considered that to be a priority. They just listed case management services, housing, self-help and programs of personal support. Those types of programs would be a priority, but when it comes to employment, they put that at the back burner.

So they formed a working group. We're not interested in working groups, we're interested in seeing what action there is, what actual programs there are, how people can access funding and create programs, businesses or whatever, to create jobs for people to help them get off the welfare rolls or disability rolls, for those who want to. It should never be a mandatory thing, but for those who want to, to help them get into the community, be reintegrated.

We also recommend some form of professional association or body or something governing mental health workers in the community mental health field to ensure continuing education and standards for all mental health workers and all mental health programs. At the present time they're unregulated. You don't know who you're hiring or what's going on in the services or in the agencies. Some of them have very good people. The majority of them in fact do. But there may be a few of them that may not, and we have to be very careful about that. We want to make sure we're getting the best services we possibly can for our dollar.

In addition, programs that have been proven to be ineffective and unrepresentative of the people they work with should be cut, if you're going to be cutting anywhere. And there's a lot of unnecessary duplication in some of these areas, and that should be examined, but not without community input and consumer input, other people's input. You don't just go in and say, "We're just going to slash this one and that one," and then end up seeing the consequences afterwards. It's always good so that people know what's happening, what's coming down the pipe, so they know and they can prepare for it adequately for the future.

An emphasis on community care models would be cheaper than encouraging people to continue using hospitals. I noticed some little bit there in Bill 26 about how doctors would only be allowed to bill OHIP for their services if they had connections to the hospital, something like that. I find that sort of against the whole principle of moving people out to the community. It doesn't create a big incentive, because some doctors may want to get involved in innovative community-based health care, whether through community mental health programs, through a health centre in Parkdale or something, maybe form a community clinic. Actually, those

are a lot cheaper to deliver. Whether a medical association might be willing to go with it or not I don't know, but I think some of these models should be tried, pilot programs set up. I think that would be very effective. You'll see how the cost savings would be developed from there.

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Also, the other thing is, a continued balance of representation from survivors, survival organizations, because not all survivor organizations have the same perspective. I think there is a need to have a varied perspective on various things. You can't just have one group because it claims to represent a whole geographic area when it possibly doesn't. You might want to have people who are having different perspectives and kind of get them around the table and try to develop some kind of consensus about how things can be developed so that everybody is happy, or at least nearly everybody. You're never going to get everybody happy, but at least nearly everybody.

Family members need to have a say in a lot of these things because family members do not have services. There's very little support. Peter Kormos has made a mention about Stella May Williams. The fact is that family members in that situation do not have a lot of support in the community, even though they get support from us, and our hearts and souls are with them, but it's just that it's very difficult for a person who's going through this for the first time—what to do, where to go. A lot of education is required in this area.

We also need to maintain the balance on the community mental health boards so that we can ensure that the services that are being delivered are being delivered to people who want them and being delivered in a way that people want them.

Thank you. I'll open the floor for questions.

The Chair: Thank you very much. You've done a remarkable job in using your half-hour. I'm sorry, there's no time left for questions.

Mrs McLeod: It's all right, we enjoyed every minute of it.

The Chair: We appreciate your presentation.

Ms Browne: I can never know how much time there is when I'm sitting here. I don't really have a good sense of time sometimes.

The Chair: You did perfect. Thank you very much.

NIAGARA SOUTH SOCIAL SAFETY NETWORK

The Chair: The next presenters are from the Niagara South Social Safety Network, Mary Beth Anger, Lydia Mazzuto and Betty Ferrish. Good afternoon, welcome to our committee.

Mrs Betty Ferrish: Good afternoon. I'm Betty Ferrish and I welcome you to the Niagara region. We represent the Niagara South Social Safety Network, which is a broad-based community group of people who work towards social justice and community development.

We regret the urgency and tight time frame we had to prepare our presentation. We work from a collective approach in our group and it was difficult to include all our points and all our people and to do this in a succinct way; however, we present our position and the wisdom

contained within. We have approached our presentation section by section.

Ms Mary Beth Anger: I'm Mary Beth Anger and I'm from Community Legal Services of South Niagara and I'm a member of the Niagara South Social Safety Network. I thank you for the opportunity to allow the Social Safety Net to participate here. We are certainly pleased to make this presentation to you.

Ms Lydia Mazzuto: My name is Lydia Mazzuto and I'm a community member.

Ms Anger: We, as citizens, believe in the right and responsibilities of a free and democratic society. We, as voters, have entrusted this government to act in a democratic process and protect the rights of all citizens whether they are rich or poor.

A democratic society respects, considers and shares with its citizens the power to make or change laws and regulations. Too often, we have not been consulted about changes and this amounts to the weakening of our democracy that citizens are entitled to have through consultation, debate and discussion. Anything less is a denial of natural justice for the members of this society and our rights to freedom.

We are responding to the items one at a time and have excluded the non-health issues in this document.

We agree that citizens from the province have the right to be heard and we understand that change is inevitable given the debt and deficit that our province has encountered. We have been living in a dream world in our inflation system and using credit financing that we never have been able to repay. Before us lies the challenging task to work towards a healthy financially secure society in Ontario.

We do not agree with one person or one office in this government having an excessive amount of power which reduces the power or input of citizens in this province. We see that abuse could arise from either the Minister of Health or the Minister of Transportation having the carte blanche power that is being suggested in Bill 26.

Our comments on the health schedules of this bill are attached and we thank you for allowing us to participate in this freedom of speech and our right to be heard.

In addressing schedule F, that's the amendments to the Ministry of Health Act, the Public Hospitals Act, the Private Hospitals Act, and the Independent Health Facilities Act, we support the right of input into the changes of legislation by citizens. We disagree with the amount of authority that Bill 26 suggests be given to the Minister of Health. We have medical experts and authorities, knowledgeable in the decision-making process, to work for the best interests of that medical community and the users of that service. Partnership decisions allow for ownership of the decisions and that the best consideration has been given to reach the solution to the problem. The closing of hospitals deserves to be studied to allow cooperation with the shareholders without holes in service while the changes are made. Often, better solutions appear to resolve the problem other than the closure of an important service. Brainstorming issues often result in solutions once the knowledge of the problem, the budget, and the discussion is known. The transition for that hospital may be to a different and better service. The

community can build itself from the inside out, but the facility closure needs early discussion to prevent the loss of the service while providing financial options that may work towards a successful future.

A debate surrounding transition for hospitals in the Niagara area is the discussion of closure of hospitals and building a megahospital. When we look at these issues we see we need major hospitals in Niagara Falls, Welland and St Catharines. The other outlying hospitals could be trauma centres and provide local rehabilitation and chronic care. This would allow a person, once they are past the acute stage, to be closer to family and friends. There are problems with some emergency department services, but these need to be resolved locally by the boards of hospitals. We have too many walk-in clinics that end up costing more money to our system, as they most often just refer you back to your own doctor. This results in two charges. We see that effective emergency departments with minor and major departments would service the community better and that hospitals would be used as intended. This is in the best interests of the taxpayer and public interest. Communities that are set apart from hospitals could benefit from walk-in clinics.

One central administration for all the hospitals in the Niagara area would be cost-effective, with a confederated board of directors. Transportation to the services of different hospitals is also a problem here in Niagara and the ability of doctors to be tied to all hospital services in the new structure would need change of policy and regulation. All these issues would need to be considered in the regional plan. These changes would promote better health care services in Niagara.

"Public interest" is not defined and we do not know what the government means by this term. We question the intention of section 5 of the Public Hospitals Act and what the government definitions surrounding grants, loans and financing mean. We disagree with the power of the ministry requiring a security agreement of repayment and the power to reduce or terminate grants and loans. All this recourse without a right of appeal or negotiation would lead to arbitrary decisions. The power of the minister is too far-reaching when the minister can deem any matter to be in the public interest. Section 8 sets the investigator up in the role of good guy, bad guy or as the benevolent dictator, which is not democratic.

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We understand some budget cuts we've been given. Hospitals where the buildings are not cost-effective could be closed. As the building becomes older and needs repair and falls below building codes, is it better to look at the financial advantages that a new hospital could offer? The major concern is servicing the medical needs of the community. We see this as public interest. Broad public input is important to the closure of any hospital. People not residing in that community would not understand what is being lost. Written financial reports do not always tell the whole story.

The excessive amount of power given to the Ministry of Health contradicts the community control process that this government advocates. The government has said that it wants to put more control in the municipalities to make these decisions more locally palatable. Will the financial

means also be given with the responsibility? The local taxpayers are already overburdened by excessive taxes. This kind of municipal power may result in large shifts of citizens if one area has the type of services they desire and the service is better than in the area where they reside.

In the Niagara region, we are fortunate we have to a particularly effective district health council which is committed to community consultation. However, we see the district health councils as extended arms of the government and therefore believe that their recommendations have the ability to be slanted and not truly representative of the people in that community. We believe that the health councils and hospital boards can again be a viable working process, with some housecleaning and new innovative ideas that can be found among the vast resources of over 10 million people in this province.

To believe that the Health minister has all the knowledge that is available would be rather shortsighted. A recent example of this can be seen in Toronto with the Women's College Hospital where the decision to amalgamate the hospital was changed after the public forced the ministry to consider public input. The amalgamation of this hospital apparently may have been a mistake. Without community input, changes would have happened that were not in the best interest of the public. Learning from this event is a lesson to remember.

Changes need to take place in hospital boards. This community board needs to be a greater representation of the community, of single parents, mothers raising children, injured workers, disabled persons, senior citizens and different levels of various aspects of medical services in the community. All the players need to be represented and not dominated by the well-known, well-established professional people on the board. A viable cross-section of the community is necessary. The decisions that were not made caused patients to suffer from the lack of a needed change and decision.

Some board members around the province are professionals who use their board position for personal status and political reasons. They have very little concern about the wellbeing of the community. To become a member of some hospital boards, it is expected that the new board member will make a financial contribution to the hospital before they are admitted to the board membership. This looks like the person bought their position on the board, and it denies low-income people the ability to participate on the board.

Too often board members do not have the time and interest to commit to the board. We are not saying that all board members fall into this category, but certainly there are some, which causes large gaps in the process that comes from healthy debate surrounding the day-to-day workings of a board. In our area, we see that tough decisions needed to be made surrounding personalities or changes in staffing but were avoided. A mechanism is needed in these cases for an outsider to make changes when the hospital board will not do the work that is needed to be done.

We do not support the broad sweeping powers for the Health minister as suggested, or that they need to be time-limited. We believe this power planned to be given

to the minister should not be implemented.

The suggestion that hospital boards of directors be taken over by an appointed supervisor for matters relating to the hospital in the public interest is a very broad statement that needs to be defined if this section is implemented. We find it difficult to understand how the minister or the Lieutenant Governor in Council would know what is in the public interest without some public input.

We state that the current system with a few changes to the broad structure has the potential to do the job of making the best decisions in the public interest. The board of directors is very accessible to the public, therefore making it easy to obtain public input to determine what will benefit public interest.

Subsection 9(1) raised the issue of accountability. The denial of accountability throughout the bill leads us to believe that the government itself does not know the extent of the change that this bill will create. Our health care system, one of the best in the world, is too important to start changing without first looking at all the possibilities that the 10 million people of this province have to offer. We realize that this would be a large undertaking, but what is important? Is it the efficient care of the community or privatization? Is this again only a corporate agenda, controlling the life of people in Ontario? Effective, efficient health care ought to be the goal.

Within the changes proposed in schedule F, we do not see any recurrent pattern of principles. People will likely die due to these changes unless community input is considered and other paramedical services are first developed. For-profit services cost more money. With the numbers of people presently unemployed or those designated as working poor, the privatization of these services will increase costs to the taxpayer. Who else is going to pay for these increased costs? Under privatization, many necessary services will be gone.

The health management organizations in the United States did pursue some of these changes and the result was the loss of empowerment by the community. The result was that two tiers of service, for those with money and those without, developed. Many free street clinics have been opened in the US to care for persons not able to access the medical system. Do persons in Ontario truly know the outcome for low-income families and singles? It is also unreasonable to allow the cabinet and the minister to be free of any legal liability for any decisions as a result of direction or level of funding. Is this proposed legislation due to the expectation of serious problems arising that may warrant legal action?

Section 32 has some merit when we have seen that hospital services feel that they are services with a doctor who does not provide the quality of care they believe that the community is entitled to receive. Most often, hospital boards do not act around these issues, for they fear legal retaliation. We believe that the connection to a hospital needs to be reviewed on a yearly or bi-yearly basis through evaluation. A hospital needs to have the strength and power to end a relationship with a doctor when it believes the need is present. We see that this is one of the areas of weakness in community hospital boards of directors.

When hospital services are below standard, we agree

that there needs to be a mechanism to revoke the licence of that private hospital. We still support that a right of appeal is inherent in this type of process.

The Independent Health Facilities Act would allow a facility fee that we disagree is a reasonable charge. We further disagree with the ability to charge this fee on top of the insured services cost. We do not agree with the change of the definition of the term "facility fee." There is the issue of privacy of information, as the bill gives the power of the minister to collect and disclose patient information. We have an Information and Privacy Commissioner in Ontario to conduct the legislation and concerns surrounding privacy and freedom of information.

Ms Mazzuto: Schedule G, amendments to the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act and the Regulated Health Professions Act, 1991: Medication for people of this province is a necessity. Like food and shelter, medications for many people are life-preserving. The lives of many could be endangered without the proper ability to have the exact drug or service required. According to London Life, one of the province's largest insurance firms, the deregulation of drug prices will cause drug prices to rise. Rising drug prices will affect seniors, women, children and the working poor in this province. This government is intent on attacking the most vulnerable in our society. Without medication, many people cannot function. Many citizens do not have the availability to shop for the best drug prices. The best drug prices may also be increased with the travel costs added to get to the location of the cheaper product. The alternative is that we will be forced to pay whatever the local pharmacy charges.

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This could lead to some serious increases for the pharmacies that happen to find themselves in an ideal location, eg, adjacent to a seniors' building or hospital. Drug pricing at a reasonable rate is not guaranteed. This leaves the fate of these prices in the hands of the large corporations and drug manufacturers. Most corporations do not have the public interest as their primary goal. Profit is their goal. We do not support putting the health care programs on the chopping block at the expense of increased costs and inability to pay costs to the health care consumer.

Poor seniors and persons on public assistance have to stretch their dollars to an impossible extreme. With dispensing fees, someone supported by social assistance will not get the medication they need. Will the result be hospital confinement a few weeks later? Will it result in family and children's services needing to be called as the child is not having its medical needs met? There are many resulting problems that will likely arise that will cost the taxpayer a greater cost when we put in place dispensing fees. This is an unfair, risky burden left on a patient.

Generic drugs will also be used and a local pharmacist advised that persons requiring the non-generic drug will have to pay the difference. This is unfair, given that many persons do not get the same medical benefits they need from generic drugs as they would from the brand-name. This will again only cost more when the person has to return to the doctor when they are again not well.

Many persons can take generic drugs, but there are also those who cannot. The money spent on the generic drug is wasted. We believe that it is important to try the generic drug, but it is imperative that if the name-brand drug is required, it can and will be given. The wrong drug prevents the person from proper function and often increases the side effects of the medical problem, incapacitating the patient. Therefore, all drugs need to be covered.

The Ontario drug benefit plan covers 2.4 million people, of whom 1.2 million are on social assistance. The Ontario drug plan covers over 2,000 drugs at present. Many drugs are used for medical problems other than for the primary diagnosis for which the drug was developed. Iatrogenic medical problems will result in greater costs. Alternative health care and other disciplines need to be covered, as they are often cheaper and work more effectively than drugs without side effects.

The inclusion of the Ontario Medical Association negotiations needs to be maintained.

A method of saving many dollars in the drug care system would be to have a central provincial or regional purchasing service to provide the medication of all persons on social assistance or using the Ontario drug benefit program. The ODB program could use one contracted drugstore chain. This would encourage competition at the renewal time of the tendering of the contract.

The Common Sense Revolution stated that there would not be any cut in health care spending. What was stated was that the health care system was too important. We agree that we do need to root out waste, abuse and health care fraud, mismanagement and duplication. The Common Sense Revolution went on to say that "Every dollar saved by cutting overhead or by bringing in the best new management techniques and thinking will be reinvested in health care to improve services to patients." This is an excellent approach and we suggest that providing preventative programs is where the savings need to be put. We suggest that a vitamin therapy program for all those persons in the optional Ontario drug benefit plan be provided. This could assist with the lack of nutrition of persons on social assistance.

Schedule H, amendments to the Health Insurance Act and the Health Care Accessibility Act: The changes of schedules H and I put in place extreme powers over doctors. We do not agree with the power, although we do see that when an area has several poor doctors practising in the same area of medicine and the patient leaves the area to find better doctors farther from home and the services of distant hospitals, this does not support the local medical economy. Therefore we see that the present system has inherent problems. We believe this is a problem that hospital boards fail to address. We support medical teams under good medical supervision from well-known, qualified doctors appointed or elected by the OMA.

Another plan to ensure quality care to outlying or northern areas would be to require doctors to serve three years in rural areas before they can locate permanently. This is part of the practice for theology graduates. We support this type of process. We support the OMA taking action to retrain doctors who have failed to keep up with

the new trends in up-to-date medical practice or to limit the area of practice when a doctor cannot meet the standard.

The OMA ought to be able to review doctors who have received several complaints of concern, and not necessarily complaints that are pursued by the College of Physicians and Surgeons. Sometimes doctors or other medical professionals may become careless in their daily routine recording or prescribing practices. In life-threatening situations that can arise, a doctor needs to be able to withstand scrutiny. Good doctors do not fear standards of practice and are not afraid to be evaluated or reviewed.

Section 17 of the Health Insurance Act that approves in the government the ability of setting out criteria for necessary services and the basic fee payable for any insured service. This can result in some doctors cutting their services when they are not paid adequately for the service that is requested. Again, there is no mention of an appeal process to negotiate any of these issues. The OMA and the government have cooperatively defined the services covered under OHIP and rate of payment for various services. We support the continuing of this practice.

The government could make decisions based on the age of the patient, the type of medical condition, the severity of the illness, the ability of the patient to pay, top-up services and any other criteria that the government decides to use to remove services from the list of covered services. This could open up a two-tiered method of delivery for medical services to patients that could lead to discrimination against the elderly, the disabled and unprotected children.

We're going to the next page, third paragraph. In the Health Care Accessibility Act, we disagree with the minister extending to hospitals the ability to charge fees for services to insured persons. This contravenes the Canada Health Act, and we believe that this is one more penalty for being poor. It is the poor people who will not have the money to pay for the services requesting payment for food, accommodation, toiletries and operation room costs. This is in direct conflict with the statement above regarding the Common Sense Revolution of Mr Harris.

Mrs Ferrish: Schedule I, the new Physician Services Delivery Management Act, 1995: We support a strong relationship between the Ministry of Health and the OMA and do not agree with the stripping of the agreements that have been made between the OMA and the government. This act voids these agreements without any negotiation rights. This will make the OMA of little force or effect in our province.

The HMOs, the health management organizations, in the US are similar, but they have the ability to make important decisions, and sometimes not wise ones. Community legal services works closely with a similar body in the working of law in Ontario with the Law Society of Upper Canada, and we support the same process, working with the OMA.

In conclusion, as Canadians we are proud of our health care system and our concern for our fellow citizen and their best medical care interests. We have not supported some in our province having the ability to receive greater

services whether they are rich or poor. The same basic medical care is administered to all in Ontario. We cannot support any change that would deny even the poorest medical services and care. We cannot accept user fees. We see that many of the cost-saving suggestions will only make money for those corporations in this country, which are already receiving most of the wealth in Canada, and we will not accept the Americanization of our province's health care. We are Canadians, and around the world we are set apart. We are truly a distinct society and culture. We want this and the Canadian way of life to continue. We can work towards a better, more efficient system, but we do not want to be Americanized. Those making the decisions in Bill 26 can hardly know the effect of these changes. We state that privatization of more medical services will destroy the quality of medical care and health care that the people in Ontario have enjoyed in the past.

The Chair: Thank you for your presentation and your interest in our process; we appreciate it. Have a good afternoon.

1600

ONTARIO PUBLIC SERVICE EMPLOYEES UNION, AMBULANCE DIVISION LOCAL 264

The Chair: Our next presenters, from OPSEU ambulance workers number 264, Mark Lowell and Larry Butters. Good afternoon, gentlemen. Welcome to our committee.

Mr Mark Lowell: Good afternoon. I'm Mark Lowell. Larry Butters is going to start off.

Mr Larry Butters: I made a presentation kit, and I'd just like to go through. We got notified at the last moment that we had a time to make a presentation. I'm very happy we can, because we feel that as ambulance officers in Ontario we serve the province, and we feel that our jobs are in jeopardy from this bill. So we're very glad to be here.

I have been an ambulance officer for 24 years in Port Colborne. My involvement in the labour movement includes being president of our ambulance Local 264 of OPSEU, I'm a region 2 director of the ambulance division of OPSEU and I'm co-chair of the provincial negotiating team of the ambulance division. I'm a member of the Port Colborne and District Labour Council, and I served as a member on the health team for OPSEU during the social contract negotiations. I feel that my experience and history in the industry qualifies me to speak on behalf of my fellow ambulance workers, and I strongly urge this committee to pay close attention to our concerns.

Over the past 10 years, there has been a number of comprehensive reports concerning the provision of ambulance care in the province of Ontario. They are: the Windsor study in 1985 done by the Ministry of Health; the Shapiro report in 1989 done by OPSEU; the McLeish report, which is an inquiry into the air crash where some of our brothers were killed; the Swimmer report, done by the previous government, and it was quite in depth about what should be done with the ambulance services; and just recently the Donner inquiry, which dealt with some

deaths.

Every one of these reports over the span of the past 10 years has come to the same conclusion: that the present system remains fractured and convoluted and, if the best interests of the public are to be served, it would be best to have one rationalized ambulance service.

Right now, service delivery is done in a number of ways: by the ministry, which is this area and Niagara Falls, Welland and Fort Erie; hospital, which is St Catharines and Niagara-on-the-Lake; and private services, which include myself in Port Colborne, west Lincoln and the outlying Dunnville area. We have no municipal services, of which the biggest is Metro, but there are some smaller ones; also, volunteer services throughout the province.

The facts and figures provided by the Ministry of Health through the transfer payments clearly show that the most expensive way to deliver ambulance service, per call, is the volunteer services.

The facts come from the Ministry of Health that we obtained through the social contract, and it lists how the transfer payments are used. I've used my calculator to figure out some of the costs.

The volunteer services, of which there are approximately 13, is \$337 per call. The reason it's the highest is because for the volunteers—they're not really volunteers; they do get paid—the number of calls are far between and they have standby rates. They're in rural areas and their calls are usually long; their average calls go from 45 minutes to an hour and a half to transport somebody. Volunteers are costly; there's not that many of them and their call volume is very low.

The private services, of which there are approximately 69, run a close second at \$258 per call. Municipal-based services, of which there are approximately 17, Metro being the biggest, is \$229 per call. For the hospital services, approximately 16 of them, the cost is \$173 per call. Last but not least, the ministry services run at approximately \$150 per call.

This sort of tells us that maybe the private is not the best way to go in terms of being cost-efficient. The difference of over \$100 per call between the privately and ministry-run services can be explained by the following:

(1) You have higher cost and wages because of a higher ratio of supervisors to employees.

(2) You have a compensation package that the owner-operators get. That means they get paid a compensation package dictated on their call volume; they run the service, so they get paid to operate.

(3) They have a higher rate of paid absence, a higher ratio of sick leave.

(4) There are 67 different benefit plans because of the private operators, not one central plan, and that's a higher cost. The figures show that could be as much as \$6 million in savings to the government.

(5) The private operators also have a higher rental cost. Most of the ministry services and the hospital services are run out of a hospital. What the private operators do is have a limited company to run the ambulance service; they also have another limited company where they rent to the government. The facts and figures prove that in some of the smaller areas they charge the same rent as if

you're in downtown Toronto. So some of the figures are expanded, and the difference between hospitals and private is almost \$6 million. There's an extra cost of over \$6 million that could be saved.

All these facts and more came to light during the process of negotiating the social contract. The government of the day agreed that one provincial service would be cost-effective, but were reluctant to implement it because of the initial cost of the buyout from private operators; the private operators' compensation package would have been approximately \$2.5 million. The government, if they had paid that out, in two and a half years would have got that money back and would have been saving money from that point on.

This scenario brings me to Bill 26. The government's title for Bill 26 is the Savings and Restructuring Act, 1995—major changes to fix a system that doesn't work; redesigning the public sector to improve productivity while delivering important services more efficiently and at less cost.

It should be obvious to anyone that to further privatize ambulance services is not cost-effective. Niagara region has a ministry-run service, private and hospital-based systems. By far, I have demonstrated that ministry or hospital-run services are less expensive than any other.

I have seen first hand, as a front-line worker, how quality care to our patients is the obvious primary goal. Just as obvious is the need to deliver the public services in a cost-effective manner. I encourage the revolutionaries of Mike Harris's government to listen to the care providers. We know how money is wasted. We have some answers. We have seen the fraud. We know the cost of strikes, the cost of poor labour relations—the list goes on and on.

When profits become part of the equation in ambulance, or health care in general, patient care and delivery of services diminishes and ultimately disappear.

Bill 26 invites profit-making corporations, private American companies, to convolute this system that is already fractured and struggling to work efficiently. If you are truly interested in common sense, let us participate in really fixing the delivery of ambulance services. One of the "fixes" could be a two-tiered system of delivery.

1610

Mr Lowell: My name is Mark Lowell. I'm a provincial employee; I work in the ambulance service in the Orillia-Haliburton area. I was the three unions' representative on the Swimmer committee and basically lived and breathed the system for some five years to see it end up in obscurity, the way all things seem to end up in obscurity when the government doesn't really put a commitment into where it wants to go.

I would hope this government would look at the ambulance service as the first link in pre-hospital care, look at that linked with some kind of vision as to what they would like to see happening in the communities they represent.

I would hope that the politicians in general would see that with deteriorating finances and closing of hospitals, reorganization and restructuring of hospitals, the redirection of long-term care, a vast number of people is being

put in situations at home that used to be common in hospitals, and when they call for an ambulance and an ambulance arrives at their door, they should be getting the same care regardless of where they live. I don't think people need to be penalized because they happen to come from a rural or northern environment.

It's quite interesting to see at least two previous Health ministers at the table today. I know they both had a shot at fixing the ambulance service when they were in power. Before the government of the day beats its chest about what it's going to do, it should remember—I've been around since Frank Miller was the Minister of Health and I've seen governments make attempts—feeble, some very grand—in fixing the system.

I want to take you on a quick walk through history back to when the Conservatives, the Big Blue Machine, was running the province of Ontario. A gentleman by the name of Dr McNally got it in his mind and was able to convince the Davis government of the day that he was going to create a province-wide paramedic ambulance service that was going to be the example for pre-hospital care in the world. Had he been able to fulfil his agenda, we wouldn't be here today because the job would have been done, although he did it a little too expensively and it was canned. That was in the early 1970s.

His idea was to take ambulance workers, put them in university courses in Kingston, train them through the hospitals in Kingston, kick them back out into the local communities as paramedics. They would be trained as respiratory techs, IV techs, they would be able to do manual defibrillation—a wonderful array of skills. They were, I guess, the arms and actually had part of the mind of the physician.

Unfortunately, when they sent these workers back out to places like Peterborough and ambulance attendant X showed up at the Peterborough hospital and said, "I'm a paramedic now, I'm going to do all this stuff on the road," the doctors in those communities said: "Under whose authority? Who gave you the right to do this?" And it never happened. It was a very expensive waste of time, with good intentions.

Because I'm a civil servant, I'm certainly not happy with Bill 7 and what it could do to workers should this government attempt to fix the ambulance service. But because you have that hammer, you can get around some of the things that possibly caused the previous government some concern in fixing the ambulance service. You don't necessarily have to be nice people about what you're doing. It gives you an opportunity to go in and say to the private operators, the hospital operators and the Ministry of Health, "We have a vision of how we want to provide ambulance service in this province and we're going to go ahead and do it."

And you can say to the unions, regardless of who they are: "If your members want to work in this system, they're going to work in this system under this vision. There are going to be province-wide paramedic ambulance services, so when you respond to that call in Moosonee, or in Longlac or in Metropolitan Toronto you're going to get the same care." Granted, because of the geography involved, the travel time is going to be different, some of the skill levels are going to be differ-

ent, but there has been study after study after study.

You're the government of the day, you have the majority, you have the ability to make change. The other parties in opposition to this government have been in the position to try to make change. I think everyone knows what needs to be done. We need to have a province-wide paramedic ambulance service, period. British Columbia walked down that path some 20 years ago, and it's taken them up until two years ago to actually have every ambulance service in the province under one roof, with one direction providing a standard of care that's equal across the province. It didn't happen overnight, and I don't expect it to happen overnight in Ontario, but it would certainly do my heart good to see a government take it on and turn it into something.

I would hate to see a return to 35 years ago. I do have to say up front that I find a lot of the legislation from this government is very regressive. In the wrong hands, if you march down the road of privatized health care and private ambulance services, as an example, you'll be taking us back 35 years. And 35 years ago in this province, when someone was hurt on the street, out in front of this building, a private ambulance service rolled up to the door and, if you had money, they'd take you to the hospital. Chances are that if you had money, there'd be two ambulances from two different companies rolling up to the door and they might even go out behind the ambulances and have a little fistfight to decide who was going to take you. When in doubt, if you thought the people you were picking up might not have money, you tried to take the dead person to hospital because you knew the coroner's office was going to pay you. I don't want to see it turn into that again.

I worked in a private ambulance service in the early 1970s, just as the government funding was evolving. I will tell you, and if you ask the private operators around in that day, they were going bankrupt in a very big way. What the private operators want the government to do this time around is open up the purse, hand it to the private operators and they're going to make the system better. I'm sorry. They're not. It just is not the way to run health care in a progressive, democratic society like the province of Ontario.

I would certainly welcome any questions anyone has.

Mr Bradley: With the provisions of Bill 26 giving more power to municipalities to impose user fees, although the Ministry of Health now sets the rate, a user fee, for an ambulance, we could in theory, unless the Minister of Municipal Affairs were going to amend the bill yet again, have a situation where a municipality that operates an ambulance service could charge more than when a private operator or the Ministry of Health operates an ambulance service. Is that a concern?

Mr Lowell: Yes, that is a concern. That's why I would like to see it looked at on a provincial scale as opposed to ever entertaining municipalities. Metro may offer a fine system in one municipality, but the community of Fenelon Falls, where I live, doesn't have the financial ability to offer a similar service.

Mr Bradley: If we're going to provide services across the province, we're going to have to have the resources to do so. The government is concerned about the deficit,

and understandably so, but is also going to be calling for a tax break which will cost the province \$20 billion in new money to be borrowed—\$5 billion in interest. Do you believe, in your discussions with various people whom you encounter, that they would prefer to have a diminishing of the services or higher-cost services of the essential nature you're talking about, or would they rather have a 30% tax break on the provincial income tax?

Mr Lowell: I hear you, but I think you're making it harder than it has to be. In my industry, when someone calls for an ambulance service, they want the best they can get, as when someone shows up at the hospital with a sick relative, they want the best they can get. At that point in time, money isn't the object; it's what's there and the quality of what's there.

Mr Butters: And it has been shown that paramedics being able to defibrillate has saved lives; being able to intubate does save lives. If we're going to go to full paramedics, I think we have to look at what we're going to get. Do you want to save lives or do you want to save dollars?

Mr Lowell: If you close the hospital down in my community, in Minden, where I work, which is half-closed now, you've taken the golden hour of trauma away from every person in that community. In a critical trauma situation without paramedic intervention, which we're not able to do, the golden hour is gone, because we're over an hour from hospital if they get hurt right on the main street.

1620

Mr Bradley: It would be your estimation, I take it, that this money is required to deliver the kind of quality health care service that the people of this province expect.

Mr Lowell: Yes, it is. There's \$330 million that goes into ambulance, roughly, in Ontario. Since the social contract came in, bureaucrats in the ministry services have added two layers of management without adding a car to the road. There are some options there to streamline. Those added jobs are regional dispatch managers and operational managers, who provide no form of patient care and do nothing to enhance the service to the public.

Mr Butters: We think that to rationalize the system under one provincial ambulance service would be cheaper. We've sat through the social contract and negotiating with the NDP on some cost savings, and that was done. We showed the facts and figures where we could save money and have better care. It's there if it's rationalized.

Mr Bradley: Would you be of the opinion that with a bill this complicated, changing 47 different acts of the Ontario Legislature in some way or another, it would be advantageous not to proceed to a final vote on January 29 but rather to have further hearings so that representations can be made from various communities across the province, and then when the Legislature returned for its normal session, it would deal with the legislation?

Mr Lowell: Yes, definitely. I also wish you to extend our thank you to your member who did the sleep-in which allowed us to be here today.

Ms Lankin: I appreciate the documentation you

supplied with this. Taking a look at the Swimmer report, it was a very comprehensive piece of work done recently looking at all these issues, and it came to the same recommendation you have been making for a number of years in terms of moving to one provincial service and that that be provided in the public service, not through private operators.

One of the things we're worried about in this bill is that it actually does open up the door for more for-profit delivery of health care services. Government members have said that shouldn't bother anyone as long as we've got our quality controls in, that we shouldn't worry about that aspect.

I recall a lot of stories about the for-profit ambulance services over the years in this province. I remember thinking it was a bit of a conflict of interest to be running both a funeral home and an ambulance service. It didn't give me a lot of confidence in the service I might be getting, but there are a lot of other things: the Alexander case, and perhaps you could talk about duplication of private services in Belleville and other communities. Could you tell us a little about the state of affairs with the for-profit delivery of services that exists?

Mr Butters: When you mentioned Alexander, that used to be the private operator in Welland. He was charged with fraud. He spent two years less a day in jail. They could only nail him for just under \$300,000 that he milked taxpayers for. After that, the service was taken over and they became ministry, and that's why Niagara district now is Niagara Falls, Welland and Fort Erie.

Where I worked in 1985, we were on strike for 144 days. After that strike, one of the deals was that our private operator was to sell the service. I have a new operator since 1995. What we used to do was drive tow trucks, fix snowmobiles, pump gasoline. If I were driving the tow truck and went on a tow call, I'd come in and submit my timesheet as if I were working on the ambulance. I did that for 10 years. That was fraud. Our employer was just told to sell the service: "You're out." That still happens today; it's out there. If you think privatization is going to be any different from a few years ago, the crooks are smarter now than they were before.

Mr Lowell: It also leaves questions like, why does Mr Ross in Hamilton own two separate ambulance services with two separate ambulance licences as one owner? Why is the community of Belleville serviced by two completely different ambulance services, workers organized by two completely different unions, dispatched by another private entity in the way of a dispatch centre? Why does Stratford have two ambulance services in the same community running out of two different bases with two different management compensation packages? The craziness continues.

When the person to my right was the minister, she said it was a patchwork quilt of ambulance services. Well, it's still a patchwork quilt of ambulance services.

Mrs Caplan: I never said it. She did.

Mr Lowell: Reprivatizing or increasing the privatization is only going to add to the problem. We'll be here—I'll hopefully still be around—when another government comes in another day, and we'll try to do it

again if this government doesn't get it right.

The Chair: I'm glad we got that comment directed appropriately to the right Health minister.

Mr Clement: With respect to privatization, the philosophy of the government, if I can put it that way, is actually to be non-ideological about privatization—
Laughter.

Mr Clement: At the risk of guffaws from the other side, which are predictable.

Mike Harris has always said we are always interested in how to deliver the best quality to the consumer or taxpayer at the best available price. Sometimes that means government doing it, sometimes it means the private sector doing it, sometimes it means a mixture of the two. We enter into any field looking for the best for the taxpayer. I want to make that assurance to you.

With that in mind, I have taken the liberty of trying to go through your numbers a bit. I confess I don't understand them all yet. There are a lot of numbers on this spreadsheet about the relative costs for the various parts. I did have one question you might be able to help me with. Part of any cost is overhead, your fixed cost. If you deliver something as a government or as a municipality, you can shield out some of your overhead cost, because that's part of your infrastructure as a government, whereas private operators don't have that advantage. Are overhead costs included in this?

Mr Lowell: Those are, I believe, total budget costs. In Swimmer, we discovered, or we came to a consensus agreement, that about 85% of the cost is the cost of delivery of the service and 15% is the arbitrary amount that's out there, because of wages, gas, oil, vehicles, things like that. That's not to say that better vehicles couldn't be purchased cheaper. There are things that can be done there.

Getting back to your earlier statement, I would like to advise you that your minister, Mr Wilson, has met several times with the private operators and scheduled one meeting with us, at which he didn't show up. We haven't had any opportunity to speak with the minister.

Mr Clement: We'll have to deal with that scheduler, obviously.

Mr Kormos: Oh, blame the scheduler.

Mr Clement: Well, it was worth a try.

Could I ask you a question about the OPALS project in Ottawa region?

Mr Lowell: Yes, Ottawa-Carleton.

Mr Clement: We've plowed \$15 million into that pilot project, and there's an opportunity to have paramedics and defib in the ambulance. Is that part of the direction?

Mr Lowell: That is certainly the direction to go in. The only thing that again adds to this patchwork and causes concern to communities and to workers is: Why is Ottawa getting paramedics? Why does Hamilton have paramedics? Why does Toronto have paramedics? Why are they going to Peterborough? Why not to Barrie? Why not to Orillia? Why not to Minden? Why not to Haliburton? Why not to—

Ms Lankin: Port Colborne hospitals.

Mr Lowell: Port Colborne, sure. I understand why it started in Ottawa-Carleton. It was by a community group called Action Paramedic and a group of physicians in that

community who brought extreme pressure to bear on the government. They squeaked and they got greased, but you shouldn't have to do that.

Mr Butters: One of the things we believe is that the paramedics should be across the province. It's fine for paramedics to be in the cities. Their response time to a hospital is less than eight minutes, and that's great. But what about rural Ontario where paramedics setting up IVs and having their skills expanded in rural Ontario would serve us better? They have a longer distance to the hospital. With intubation, IVs, they would stabilize a patient. But what they're doing is going to the big areas and leaving the little areas. I think it should be province-wide, and hopefully that will be there.

Mr Lowell: I'd like to add just quickly that when you look at money, when you fall on the sidewalk in Toronto, why do they send a police officer, a pumper truck and a station wagon? Why send nine other people when all you need are two workers and a van? I mean, that is the answer, and they say, "Well, the fire departments have better response times." Why is that? Because geographically ambulance services have never been located where they should be, I think is the point.

1630

The Chair: Thank you very much, gentlemen, for a very interesting presentation. We appreciate your being here this afternoon.

Mrs McLeod: Mr Chairman, you'll appreciate the fact that because we've not had anybody with the subcommittee who's responsible for carriage of the bill, and in fact the Minister of Health has not been present for even a portion of any one of our hearings of the health subcommittee, so we've not been able to place questions directly to the Minister of Health, I would wish to place a further question on the record.

We have had numerous presentations that have indicated that the deregulation of drugs will in fact drive drug prices up. We've had considerable evidence presented to back up that case and virtually no evidence presented—I think two opinions that have been offered in total that have suggested drug prices could decrease, or at least ultimately decrease after perhaps five to 10 years.

I would like therefore to have the Minister of Health's rationale as to why they would be deregulating drug prices, which will clearly, as prices are indicated to increase, not provide better health care to individuals at less cost. I would like to ask whether there's any rationale other than the ideological commitment to deregulation and privatization.

The Chair: Thank you, Mrs McLeod. Mrs Caplan.

Mrs Caplan: Following the last presentation—and I will only take a couple of minutes—what we heard, I thought, was quite an astounding admission from the last presenter that he had been forced by his employer to participate in fraud over a 10-year period, employer fraud. I had expected that the government members might have said something about that since we've heard that this government has a zero tolerance for fraud and that many of the policies of Bill 26 recognize that. I'm also aware, for example, that the Minister of Community and Social Services posted offensive posters saying if you even suspect anybody of fraud, call this 1-800 number.

That was their snitch line.

I know the reason that employee wasn't comfortable to snitch on his employer was because he'd lose his job if the employer found out. I'm wondering whether or not the Minister of Community and Social Services and the Minister of Health contemplate employees such as that being able to use the snitch line anonymously to be able to report ambulance employers who are committing fraud, or what the government would intend to do. We've heard today testimony that this practice continues today. The government should be concerned if that kind of fraud is being perpetrated. I want to know whether they are suggesting to this person that they call the welfare 1-800 snitch line or if they have some other mechanism to deal with that kind of fraud contemplated in Bill 26.

K.N. REDDY

GREATER NIAGARA MEDICAL SOCIETY

The Chair: Okay, Dr Reddy. Welcome to our committee. We appreciate your being here.

Dr K.N. Reddy: Chairman and distinguished members of this committee, thank you for the opportunity to express my personal views about Bill 26, referring to schedules F, G, H and I. I'm a specialist in urology, practising in the city for over 20 years.

All of us would like to see that the health care costs are brought under control and to live within our means. Successive governments have failed to recognize the major contributing factors for escalating costs, such as consumer demand for the services and the defensive practice of medicine.

This bill is dictatorial and will have a far-reaching demoralizing effect on the physicians and makes no sense in this democratic society.

Ministry of Health officials will have the power to seize medical records from the doctor's office. This is unthinkable. The ministry can ask the physicians to repay the cost of service if they think it was not necessary. So are we to take permission for each service provided, or will the ministry give us a list of tests and procedures allowed for each clinical condition? This will create a bureaucratic nightmare.

It is time for the honourable Minister of Health to sit down with the representatives of our medical association and work out a plan to achieve the common objectives of cost containment and manpower distribution.

Thank you. I will leave the rest of the time for questions because this bill is so extensive I do not wish to go through it any further, apart from answering questions.

The Chair: Thank you, doctor. I guess we'll have to skip the New Democrats. They don't have anybody here, so we'll start with the government.

Mrs Johns: Go ahead and start and I'll finish it for you.

Dr Reddy: If time permits, I can give some of my time to the following speakers if you want me to. But I'm prepared to answer your questions, sir.

The Chair: I know the next two and the last two are also two doctors for the region. I don't think we have any problem if the three of you want to share—

Dr Reddy: Maybe I will answer one or two questions

from the Conservative government and then I'll give my time to my successors.

The Chair: Okay. That's fair.

Mr Clement: As you know, the committee, both the opposition and the government members of the committee, are considering amendments to this legislation as part of what a committee does, and we've been hearing presenters over the past three weeks. If we did entertain that as a committee that would strengthen the ability to maintain the anonymity of the names involved in medical records but still allow investigative powers to occur, so that if there is any misuse of the medical system—we don't want to be, as taxpayers, spending dollars in a way that is a misuse of the system when there are so many crying needs in the system in other areas. But if we could alter our plans to provide for the proper balance between confidentiality and an ability for investigation of misuse of the system, would that go some way to addressing your concerns?

Dr Reddy: With due respect to your comments, already we have an existing system of peer review. I do not mind the peer review person from the college coming in and investigating my office. We are open for that. But a bureaucratic person from the Ministry of Health is unthinkable. I think this is the most objectionable legislation which you have created. I think this is unacceptable.

Mr Clement: So if we changed that, that would satisfy you?

Dr Reddy: As long as the college is involved, not the Ministry of Health.

Mr Clement: I understand. Am I allowed just one question?

The Chair: I don't know how we're going to do this here. Do you want to keep asking questions or—

Mrs McLeod: If we are planning to have the time of the physicians shared in terms of presentation and then share the question time with all of them, I would hope we're going to have still an equitable distribution of time.

The Chair: We'll do the best we can.

Mrs McLeod: If we make the decision, let's make it now.

The Chair: Okay. Mrs McLeod, did you want to ask a question?

Mrs McLeod: We have a number of questions. We'll ask one question now.

The Chair: One question now and then we'll bring the other two doctors up. Is that fair?

Mrs McLeod: We can conclude within 20 minutes.

Mrs Pupatello: Thank you, doctor. We heard a presentation from a doctor who was from Leamington but who at one time practised in California, and because he saw so many similarities to the American system now being allowed to come into Ontario, he gave us an anecdotal case where a surgeon was just about to pry into a patient for a particular procedure—it was a tube of some sort—and the phone rang and it was a clerk from one of the HMOs. The clerk reviewed the file and saw that this patient wasn't covered. The events leading up to the surgeon preparing for the incision were that there were several emergencies that had precipitated immediate surgery and this sort of thing. When the phone rang, the surgeon was told to stop because the patient was not

covered. This is the kind of event that will be allowed to happen because there are provisions in this bill that will allow for American companies to come in, that will allow for this kind of thing to happen, which has to date never been the case. Do you have any comments about that?

Dr Reddy: As you know, Canada and Canadian physicians are very compassionate. We may be prepared to do the service free if the operation was necessary, if it's covered or not covered. You must understand that we are very compassionate people. That's important.

The second question: If somebody asks me to stop the operation, if the patient requires it, I'll still go ahead and do it, free of my cost. But if it's not needed, then it's obviously my fault. But certainly I do not like to see the government take the steps to tell me to do this operation, not to do this operation. I think this is totally meaningless, senseless legislation to bring out, saying that the ministry will decide if this procedure is covered or not covered, this test was required or not required. Let us decide. Let the professional and provider decide what is necessary and what is not necessary. Let my peer committee like the college of surgeons decide if my decisions were appropriate, not the ministry. I think this has gone too far.

1640

The Chair: Thank you, Dr Reddy. We'll invite Dr Kevin Smith and Dr Leonard Makerewich.

Mrs McLeod: Mr Chairman, can we just determine exactly what we're about to do, because I see the last presenter is leaving. I think we want to be clear. We want to use the full time that the committee has until 5:30. Is that correct?

The Chair: If everybody's in agreement, why don't we have all three doctors? Dr Makerewich and Dr Smith can make their presentations, and all three of you would be available to answer questions. Is that okay with everybody in the committee?

Mrs McLeod: And can they all remain until 5:30, which is the time the committee has? We would certainly take all the time until 5:30, should that time be available to us. So we would be happy to have an in-depth discussion of the issues affecting physicians, and this may be a unique opportunity, with three physicians here, to have an intensive discussion about the issues in Bill 26. So if the physicians who are here can join us, that would be highly desirable from my perspective.

The Chair: I presume they will stay as long as they can up to 5:30.

Dr Reddy: Until tomorrow.

Mrs McLeod: Until tomorrow? We're here too. Good.

Dr Leonard Makerewich: I'm Dr Makerewich. Nice to meet you. Dr Kevin Smith and I actually will be presenting on behalf of the Greater Niagara Medical Society. I am an otolaryngologist, or ear, nose and throat specialist, and president of the medical society. Dr Kevin Smith is a dermatologist, or skin specialist, and he's vice-president of the society. Today we're here as Team Niagara. We'd like to make a few points and we'd certainly welcome your questions.

The doctors of the Niagara region would certainly like to welcome the members of the committee to Niagara Falls and we'd hope that if there was any possibility of

any free time, you'd take advantage of that and go down and see one of the wonders of the world here, especially its winter coat. It's quite nice, and if you did have any time we'd certainly think that would be nice.

We'd also like to recognize the expertise and the knowledge of the two former Health ministers who serve on this committee.

What we want to say here, and I'll go through this probably as briefly as I can, is that coming into the last election certainly the doctors in the Niagara region were very impressed with the sincerity of Mr Jim Wilson prior to the election in terms of his proposed cooperation with physicians when he met with the Ontario Medical Association. He came with an outstretched hand. He came and made a presentation to the OMA stating that he really desired to heal the wounds that had been created with some of the former governments. Certainly since then and since we've heard about this proposed legislation, we've not only been shocked, we've been dismayed at some of the draconian proposals that have come through in this Bill 26. These proposals are going to affect every physician in this province and every patient in this province.

When we went into medicine—I can speak personally and I can speak for my colleagues as well—we went into this with a purpose. We wanted to work hard. We wanted to serve our patients. We wanted to make a decent living that recognized our training, our workload and our heavy responsibility, and the hours that we spend after hours and midnight away from our families. Little did we realize we would have to start learning how to practise politics just to be able to survive in the practice of medicine in the 1980s and also in the 1990s.

Had the government come to the OMA in private with the draft legislation prior to introducing Bill 26, these public hearings wouldn't be necessary. Doctors, like other independent business people in this province, fully support the fiscal objectives of the Harris government to reduce and eventually eliminate the deficit. The deficit, both at the provincial level and at the federal level, is probably the scariest thing that we have now in terms of downloading all the things that we were supposed to have had for free over the last 15 or 20 years to our children and our grandchildren. It's quite frightening, and we strongly feel that this has to be dealt with. The problem is that we feel more can be accomplished with cooperation with the medical profession rather than the confrontation that's going to occur with the medical profession if Bill 26 is passed in its present form.

We feel that many of the proposals in schedules F, G and H relating to privacy of information and examination of health care records assume that physician fraud is a major problem in the current system, and it's not. I think that if there was a very close audit of everything that would be done here in terms of looking at physician fraud, it would be a very, very minor part of the problem, an extremely minor part of the problem. I think most physicians bill honestly and they work very hard. I think, really, that the major cause of spiralling health care costs in our present system is the lack of patient or consumer accountability for the use of the medical services that are out there now.

Most physicians' telephones in this day and age are

ringing off the hook, and we're so busy trying to satisfy the insatiable demands of our patients for so-called free medical services and high-tech investigations that we're doing everything possible not to encourage repeat or follow-up visits unless absolutely medically unnecessary.

Many patients feel that they have an unlimited right to three, four or five medical opinions at government expense until they hear what they want to hear or until they get the prescription that they were really after in the first place.

If we don't satisfy our patients' demands for timely access to our offices, they usually go down the street to the walk-in clinics or to the emergency department, and if they're referred to specialists after hours, this ends up billed to the system and sometimes ends up in after-hours premiums. There's no savings in the system. There's no savings in our rationing care and cutting back our services to our patients. They go elsewhere, and when they do go elsewhere, it costs us even more. It costs the entire system more.

Doctors are presently providing the medical services that the citizens of Ontario are demanding, and we're being financially penalized for doing so and we're being accused of overbilling the system when the level of physician payments exceeds a predetermined government cap. This government cap was so-called negotiated with the last government, with a gun to our heads.

The major problem with our present system of universal access to health care and total first-dollar coverage under the terms of the Canada Health Act is that it's unaffordable. It was unaffordable and was paid for with borrowed money back in 1984 and it's unaffordable today. The problem is our fiscal reality and the sad state of our provincial finances now.

With continuing cuts in federal transfer payments for health care to the provinces, the Canada Health Act will shortly become an irrelevant document, and it's going to lose its financial control over the provinces, which are already shouldering the major burden of health care costs in this country.

Doctors have already absorbed 30% to 40% cuts to 1991 level fees because of billing caps and because of social contract reductions, and we've done this in the face of ever-escalating office and practice costs and we've maintained service in spite of all that. We're getting to the point where we cannot tolerate any more, both fiscally and realistically.

We've done our share and many of us are at the top of our credit lines. Many of us are starting to have problems meeting our expenses. Most people feel that every dollar that we take from the ministry is a dollar that goes into our pocket. Some of us only get five cents out of that dollar after we've paid our overhead costs; some of us more, depending on the level and the size of the facility that we've developed, the salaries that we have and so forth, the rents that we pay. We're small, independent business people and we have expenses as well, and this all comes out of our OHIP billings. We're working as hard as we can now to satisfy our patients' demands and we can't continue to provide the high-quality medical services that we've been providing in the past with the present level of fees, and certainly if they should go

down even further.

Many of us have spent anywhere between seven and 12 years in training at little or no pay prior to entering the profession, and we continue to work between 50 and 90 hours a week serving our patients, away from our families, after hours, in the middle of the night.

We can't look to government for additional funds. The government doesn't have those additional funds, and we understand that. We feel that the consumers of health services finally have to become accountable for their own health care costs and that the government and the medical profession both should ensure that no one should suffer financial disaster because of a need for expensive health care services.

The proposed restriction of billing numbers for new medical graduates will send even more of them out of the country. A carrot has always been more effective than a stick. The OMA's proposal for rural and underserved long-term financial incentives is far more realistic in solving the problem than what the government proposes.

The removal of any right of appeal for physicians challenged by government on the appropriateness, retrospectively, of medical services is draconian. It can't be tolerated by the profession.

Significant savings can be made in the system not only by downsizing and some of the measures that are being taken now, but by defining core services and knowing which ones are essential services, by delisting non-essential services in cooperation with the OMA.

When we look at some of the terms and conditions of the proposed regulations in Bill 26, we think to ourselves of the size of the bureaucracy that will have to be created to micromanage the doctors under this new legislation. I thought the Harris government was into downsizing. Am I wrong?

I'd like to turn over the next part of the presentation to Dr Kevin Smith, our vice-president.

1650

Dr Kevin Smith: At the outset, we've been focusing for a number of months now, ever since the election, on the cost of medical services. I want to mention the value of the medical services that are provided and the value of the medical care system we have here in Ontario.

We do as good or better a job than the Americans and we only spend about 10% of our GNP on health care, while they spend 14%. We care for all the people in this province and we provide a very good quality of care for all the people of this province, while in the United States, considerably more money is being spent and many people are being left out in the cold. An increasing number of people, I think, have inadequate access to care or hardly any access at all.

The doctors, the nurses and the other members of the medical community are very proud of not only the quality of our system, the quality of the work we do, but also the efficiency of our system, the fact that we're able to obtain good results, give good care to all the people and do so at a considerably lower cost than our friends just right across the border.

Moving on from that, there is concern that people are sometimes afraid that we're going to develop a two-tier medical system. We already have a two-tier or multi-tier

system for access to medications and medical devices. For example, people covered by the government-funded drug plan have access to a limited range of medicines and medical devices, while those with private coverage or cash have access to a broader range of products.

Another example would be that people covered by workers' compensation in some cases have preferred access to certain specialists, to diagnostic procedures and to medications which are not available to people who are covered by the OHIP pool of resources. The reason for that is simply that because of capping, an increasing number of specialists, are reaching their fee limit within the OHIP pool and they have to ration out the number of consults they can see every month to make them last all year long. So if a patient calls for an appointment and it's a workers' compensation case, of course there's no waiting list for them because the limiting factor is not the availability of my time; the limiting factor is the availability of money to pay for the services and investigations that are required to take care of these people. So if it's, for example, a WCB patient, they can get seen much more quickly in some cases than exactly the same person with exactly the same problem who has OHIP coverage.

Another example would be somebody from outside of the province, either from outside Canada or from another part of Canada, somebody coming in who is going to pay cash. Again, there's no waiting list for people who want to pay cash because the availability of physicians and operating rooms and other resources is not the limiting factor. That's not the bottleneck; the bottleneck is the availability of money from OHIP to pay for all these good things.

People in this province are free to spend their money on cigarettes, liquor, lottery tickets, lap dancers, so it seems strange that the people of Ontario are forbidden to spend their money on a higher standard of convenience or a higher standard of medical care than that dictated by the government from time to time. As I mentioned earlier, Americans and other people from outside of Ontario are free to come to Ontario and spend their money for medical services while the people of Ontario are forbidden to do so and must leave the province to purchase medical services. In this respect, outsiders actually have more freedom in Ontario than the people of Ontario do.

Just in yesterday's newspaper there was an ad from an American company that is offering joint replacement therapy. A person in Ontario would have to travel down to Virginia and spend their money in a strange place where they don't know anybody to have this done, but they're forbidden to spend their money to have this work done at their own expense here in Ontario, and that would be one less case sitting on the waiting list to be covered by the OHIP pool. I find that very difficult to understand, especially when these same people are, as I said, free to spend their money on liquor, lottery tickets, cigarettes, all manner of things which are probably less desirable than medical services and probably less beneficial.

The government has progressively narrowed the definition of what is a medically necessary medication in the government-funded drug plans over the past several

years, and in many respects this has been a good change. Patients have accepted this change with very little complaint. There hasn't been any political backlash. When I explain to patients that the people of Ontario, through their elected representatives, have decided that we simply can't afford to pay for certain items, most patients are very understanding. They're grateful for what the government does provide them with, so the cutbacks that have been made so far really haven't had a lot of political consequence, nor should they. I think the patients are very reasonable in many respects.

The previous administration, under the NDP, started to take some steps with the encouragement and with the cooperation of the OMA to narrow the definition of what are medically necessary, core physician services. About \$20 million worth of items were, in one way to say it, delisted. A number of those items were in dermatology and again, the patients have accepted these changes with essentially no complaint. They understand that we've got serious problems. They understand that we can't pay for everything for everybody and that we must draw the line somewhere. So at least in my own personal experience, people have accepted these changes and they really welcome the changes. They think this is timely and appropriate, that there have to be some restrictions.

I know that you're looking for practical suggestions on what can you do to reduce the amount of money being spent. We know that you're going to have to spend less money. You want to do it in a way that's going to be effective and that's going to minimize the impact on health care outcomes in Ontario.

In Manitoba, a utilization reduction experiment was done a year or two ago where they identified the 100 patients in Manitoba who were consuming the greatest amount of outpatient resources. In some cases, these individuals were having more than 500 physician visits in a single year. All 100 individuals were contacted and surprisingly, as I understand it, all 100 agreed that in the future they would get all of their medical care through a single physician. They could pick the physician, but then they would have to stick to that physician for all their care and all their referrals.

That group of 100 people in Manitoba was spending more than 1% of the entire health care budget in Manitoba. So this small experiment not only gave these people better medical care, because their care was much less fragmented—if you're seeing more than 500 physician visits a year, you're probably being exposed to a lot of diagnostic and therapeutic interventions which are doing more harm than good, so by forcing these people, this tiny subset of people, to stick to one doctor, they saved a lot of money and I think these people got much better care too. That's something that could certainly be tried here in Ontario, and if it's successful it could be expanded to some extent. It would be in the public interest and it would be in the interests of the patients.

As we look at the legislation that's before us, one point, on page 112 of your book in section 7, where it says "Classes," I'll read into the record. It says, "A regulation may create different classes of persons, facilities, accounts or payments and may establish different entitlements for or relating to each class or

impose different requirements, conditions or restrictions on or relating to each class" of person.

I wonder, are some animals going to be more equal than others when you're finished? Why are you creating separate classes of persons? What's the intent of this legislation? Perhaps you could tell us, why are you putting this in here? This seems to be something that will divide and fracture the population of Ontario. I know we have the class of persons who are covered by workers' compensation, but I wonder, are there other classes you have in mind who perhaps deserve a higher or lower degree of access to care? Perhaps you can comment on that during the question section.

A major concern to the physicians which Len alluded to is uncertainty about chargebacks for the costs of tests, referrals and medications. As I understand it, there will be no hearing, no right of appeal and, the most dangerous of all, the minister's opinion is law. Since the Magna Carta almost 1,000 years ago, a basic principle has been that the law must be knowable; it must be published so that we can read and follow the law. In this case, the law is whatever the minister says it is, from time to time. I don't know what's in the mind of the minister today and I have no way of knowing what will be in the mind of some future minister, but I'm liable. If that minister decides that a certain set of procedures or investigations was unwarranted, even though they might have been ordered in good faith and for good reasons, I can be, as I understand it, required to pay back thousands of dollars, and interest and legal costs.

1700

Now, my take-home pay for seeing a follow-up patient, after taxes and expenses, is around \$5.50. In the course of that visit I might, in good faith, order thousands of dollars worth of investigations, medications and referrals for a certain patient. For the \$5.50 I am being paid, I can't really afford to expose myself and my family to the open-ended financial risks that this legislation may create, and other doctors can't afford that degree of risk in addition to the risks that we already accept and face. In some cases, it may be necessary for the patient to get prior authorization from some micro-manager in the government before they can find a physician willing to order investigations or treatments. In other cases, the patient may be required to agree to be personally responsible for the costs of any investigations or treatments which the minister subsequently decides not to pay for, because I simply can't accept that risk.

Because emergency physicians do not have the opportunity to obtain prior authorization from the government, and they may not be able to negotiate "hold harmless" agreements with the patients in the emergency room, it may be necessary for hospitals to agree to be responsible for any costs which the minister tries to recapture at some point in the future, or it may be very difficult for them to recruit emergency physicians. Again, the emergency physicians may not be willing to accept the risks that are associated with practising in this environment in the absence of those guarantees.

Moving on to a different subject, reduced availability of hospital resources has increased and will continue to increase the demand for and the complexity of outpatient

medicine. One of the flies in the ointment here is that walk-in clinics, in particular those which are staffed by doctors who are not on staff at the local hospital and who are not members of the local community, may be consuming resources out of proportion to the incremental benefit of the services that they're rendering. Of particular concern to the hardworking family doctors in our community is that these walk-in clinics, by skimming off the quick, easy, lucrative work, are leaving the proper family doctors with an increasing concentration of difficult, complex, poorly paid work, caring for people who have chronic problems, caring for hospital and nursing home patients and doing unpaid work on hospital and community committees. Virtually every physician who is a member of the hospital staff does unpaid work to keep the hospital functioning, sitting on tissue committees and medical record committees and other things.

Reduced prices for services will, to some extent, limit the availability of those services. Caps on incomes may also reduce the availability of certain services, and the combined effect of these two things may make it very difficult for the most demanding patients, the ones with the most complex and difficult problems, to get the kind of care they need. So if you could do a little bit to help give the OMA the tools it needs to rein in the walk-in clinics and perhaps the house call services and the GP psychotherapists and a few other things, that might go a long way towards solving your problem and improving the bottom line for the health care consumer, giving the people of Ontario better care, less fragmented care.

Another suggestion which has come forward from a number of the family doctors and other physicians whom I've spoken with, and which would be very useful in my personal practice, would be if you would put in place an information system which would contain the laboratory results and prescriptions which have been given to the patients. If this information were available, it would provide you with an excellent statistical database and it would increase the efficiency and quality of care. I could simply swipe the patient's card into my computer, find out what tests have already been done, what medications they've had. It might also give me a sense for, "Well, gee, you've seen four other dermatologists in the last three weeks; what's going on here?" or, "You've seen 14 doctors in the last two months."

That would change the complexion of the dealing with the patient and it might, again, help to limit wastage. Instead of my having to order redundant tests or repeat something someone has already done and have the patient back in two weeks, I could see what's been done, I might be able to give them better care quicker, reduce the number of follow-up visits and reduce the number of needle pokes and other investigations. Okay?

Another advantage there is that part of the cost of setting up such a system might be recaptured by selling the system to other provinces and in other countries. It seems like an idea whose time has come, and we have the computer expertise. We have the people here in Ontario who could build and maintain that kind of system and sell that kind of system. Places like the University of Waterloo and some of our major software developers, I'm

sure, could make a major contribution.

The laboratories are largely computerized already and they're already in the process of feeding this information over computer networks to the physicians. It wouldn't be a big step for you to make a central database of all this information so that it would be readily available throughout the province. If somebody had a heart attack in Ottawa and they were from Niagara Falls, their medications and lab records would be available instantly. It could be a big advantage; it could be a life-saver in some cases, avoiding drug interactions and providing higher quality treatment at lower cost to you. We'd all be happy.

Finally, I'm uncomfortable sitting here publicly chastising and correcting a government which in many ways I support. The public interest is not served by the ill-considered proposals in Bill 26, and much of this unpleasantness could have been easily prevented if the ministry had consulted with the OMA or with any physicians. You could have rounded up the people at this table and we could have probably told you most of what you need to know. We would have been happy to point out some of the more glaring problems in private and so expedite the changes to the health care system which the people of Ontario, through their elected representatives, have decided are necessary and which I think we all agree are to some extent necessary and desirable.

So thank you very much. I'd like to introduce Dave Nicholson, who's also on our executive, who has joined us.

The Chair: Thank you, doctors. We've got about eight minutes per party for questions. Ms Lankin, we missed you last time around, so we'll start with you.

Ms Lankin: Thank you very much. I appreciate having this opportunity for some extended dialogue and I appreciate your presentation.

I should at the beginning state the obvious, which is, on some things we hold a different position, particularly with respect to opening the system for those who choose to pay to get quicker service and user fees, and I think we know those discussions—

Failure of sound system.

On the other hand, I'd like to say that many of the concerns that you raise with respect to this legislation I share with you, and I believe that some of the changes that the OMA is looking for are ones that I and my colleagues would be able to support as we go through the amendment process.

The Chair: Excuse me, Ms Lankin, a problem with our Hansard machine. Okay, they got you.

Ms Lankin: I'm not sure exactly what you missed, but just for the record, I oppose user fees.

Dr Makerewich: They're called copayments.

Ms Lankin: Copayments under this government.

I do want to ask you some specifics about the legislation, but let me touch on a couple of things that I have heard OMA representatives say, which I think is an evolution in the thinking of the OMA or in the preparedness to deal in different ways with some issues.

I have heard representatives of the OMA say that you are prepared to deal with differential fees to look at resolving the issue of maldistribution of practitioners, as opposed to a billing fee restriction approach that is being

talked about. I've heard you, Dr Smith, and others talk about being willing to deal with walk-in clinics, and I welcome that. I would say a couple of years ago—it was more than that when I was Health minister and wanted to deal with walk-in clinics—that wasn't the position then. But then we were doing other things the doctors didn't agree with, and that's always the case, the to and fro in negotiations, so that might have just been at the moment.

Those are important changes, I believe, and if I've heard those correctly, I think that indicates, much like we've heard from many other people in the health care system, that doctors are also supportive of and understanding of the health reform that is taking place and that is required to take place and, within the publicly funded system we currently have, the need for those resources to be used in a wiser way.

I say that just to get a quick response from you to make sure I haven't misread some of those things, and because the government needs to hear that you are in fact willing partners in health care reform and restructuring and not just defenders of the status quo, which is what they seem to accuse people of if they oppose the government's measures in this bill.

1710

Dr Makerewich: I think that's a fair understanding. We're willing partners in the entire situation. There's more to be gained here by cooperation than there is to be in confrontation, but let me make it very clear: Beds are being closed and doctors are heading for the border. There is a problem. What's out there now isn't working, and there's a reason it isn't working, but let's agree to disagree.

Ms Lankin: The question is, will the proposals in this bill make it better then? If you've got problems with what's there now, will this make it better? I've heard very clearly from doctors that, no, it won't.

I have questions in a number of areas. Let me just start, though. Dr Smith, you raised a regulation-making power under the Health Insurance Act relating to different classes of persons and facilities and different classes of accounts or payments. I'm not sure exactly what that means, and that's not something that's been touched on in depth in the presentations thus far. I don't know if you have any response. I know you asked the question, but have you any thoughts of what that means?

And let me ask you, given that the government is eliminating the role of the OMA as a negotiating body and is going to move to unilateral setting of tariffs under the health insurance scheme, and has indicated that it will negotiate with individual doctors or groups or classes of physicians, does this reference to classes of payments mean that we could see differential payments being unilaterally set as a result of one-off talks as opposed to negotiations with the OMA? I don't know; I'm asking.

Dr Smith: I think the government is building itself the best possible toolbox. They're acquiring every possible power. Whether or not they're going to proclaim these pieces of legislation is another issue entirely, and what happens in the regulation-writing stage is going to have a lot of bearing on that. But I was just struck by the reference to different classes of persons. I thought that was a bit strange, and I find that a little worrying. I

thought we were all the same and we're all equal, but now some animals are going to be more equal than others maybe.

Ms Lankin: One aspect that concerns me greatly is the process by which the government can revoke hospital privileges for doctors, particularly given that it is restricting access to a billing number to those who have a relationship with a hospital or a facility. I have a problem with that to begin with, but if that's the case and your hospital privileges can be unilaterally revoked and there is no appeal, many doctors have said that really means their role as patient advocates within the hospital system will be—not challenged, but they will feel threatened to provide patient advocacy for their own area of specialty of practice and/or budget areas of the hospital.

There's been one amendment that has been made which actually narrows the application of this right to revoke privileges without appeal, and now it's clear that the government intends that to be the case in hospital closures and/or ceasing to provide services.

But I ask you, if you're a troublemaker doctor in terms of being an advocate for your patients and the service happens to be being rationalized over to another hospital, what right do you have to follow your patients with that service to the hospital, without a right of appeal? Does this fix the problem that your profession has identified for us through the earlier weeks of hearings?

Dr Smith: It narrows the scope of the problem considerably, but it's important for physicians who find their hospital closing or find their department closing that they and their patients can move to a different hospital. It's not just a case of the doctor being able to set up shop at a nearby hospital, but his patients also need to have access to that hospital. We may see that a little bit in some regions where people will say: "Well, this is the Niagara Falls hospital. Our taxes are paying for it, our donations paid for the CT scan. We don't want those folks from all around the countryside coming in here and consuming our resources."

I don't think that's the way that health care should evolve here in Ontario. I want the physician and the physician's patients to be able to move to another facility within a reasonable distance, and there's no provision for that and there's no mechanism for that. I think the addition of that by way of an amendment would be very helpful, both from the point of view of the physicians and also from the point of view of the patients of the physicians who are being affected.

Dr Makerewich: Could I make a comment too? You said earlier that the government then would have the unilateral right to restrict privileges and close down and so forth, and also to negotiate with different classes or different people or different physicians. The example was given of the obstetricians. The obstetricians had a meeting and are willing to tell government or anybody else to get stuffed. You either talk to us all or you don't talk to us at all. That's one point.

This is, "We will dictate, we will dictate, we will dictate." You're assuming that doctors are going to continue to obey the law. We've been held hostage by legislatures on three occasions in the past, starting with the Canada Health Act. You're assuming that physicians

are going to continue to obey the law. We're that far away from starting civil disobedience.

Ms Lankin: I need to—

The Chair: Thank you, Ms Lankin. I gave you an extra minute actually.

Mrs Johns: I'd like to thank you for your presentation today. Unlike Ms Lankin, and that's probably because she's been in the health field a lot longer than me, I'm somewhat confused by the OMA presentations over the last few days. She's got a vision that things are continuing on the same line, that you're saying the same things every day. I'm having trouble with that, so I just need to check a couple of things and go back to a presenter we had yesterday.

Is it a provision that a doctor who provides a continuum of care, for example, works in the emergency and has office hours, is worth more money, if you will, than a doctor who runs a 9-to-5 practice?

Dr Makerewich: I'm not sure of the relevance of the question. How do you mean? Do you mean in terms of fees? Each of us has our eight hours working and some of us share on-call responsibilities and some of us do shift work in the emergency department and voluntarily will cover a 4-to-12 shift or a midnight shift or whatever else. I think we all work pretty hard.

Mrs Johns: I agree that you do work pretty hard. Is there a family practitioner here? Okay, can I ask you this question, doctor?

Dr David Nicholson: Yes. I think Dr Makerewich brought up the point about the hospital privileges being linked to specialty billing numbers. Why is the government just thinking of the specialists?

In this community here in Niagara Falls we have a very inadequate supply of family doctors. It's the same in St Catharines. It's very hard for many people to find family doctors, yet within the last year two walk-in clinics have set up in this community which are staffed by physicians from out of town. They work their hours doing the light cases with low acuity, high volume, and cases which need more work—the mentally ill, the geriatric folk, people who are dying at home and need house calls, are seen by the rest of us. If the government is wanting a way to weed out walk-in clinic problems, then for urban centres like Toronto the simple way, in my estimation, would be to say walk-in clinic doctors who don't have hospital privileges don't get paid.

Mrs Johns: I guess I didn't do a good of it last time, but I came through that part of it and I understand what you were saying. The Scott report suggests there should be a different fee schedule in different areas, given the fact that they provide different services, if you will, and suggests that would entice doctors to rural and northern areas. What I heard yesterday from the OMA was that that is one of the processes they would recommend. The minister has asked that all presenters give us their opinion so we can try and resolve this problem. Have you an opinion on whether they deserve that differentiated fee and if the OMA will be offering that?

Dr Nicholson: Absolutely. I can't speak for the OMA, but it certainly has been discussed within the OMA and it has been agreed upon that it is much better to entice doctors with carrots than to beat them with sticks, and if

you pay enough money as a premium to get people up to the north or an underserved area, you will get people.

Mrs Johns: Given that we have a given amount of money to put towards doctors' fees, does that mean the urban doctor will take less so the rural doctor can have more?

Dr Nicholson: The whole question of allocation is a different process altogether. At present, of course, the physicians are being asked to subsidize the expansion, on a year-to-year basis, of the system, and that's quite inequitable, so I don't think we can use the present system as a starting point. But the answer to your question, can more money affect the distribution of doctors, is yes, obviously.

1720

Dr Smith: I'd like to introduce Dr Alison MacTavish, a family physician here in Niagara Falls, who has a very active obstetrics practice. She may be able to comment with respect to obstetrics in particular.

The Chair: Splendid. A question, Mr Clement?

Mr Clement: If we have time, Mr Chair, sure. First of all, Dr Makerewich, I'm just going to raise something you said on page 2 of your brief, that if the government had talked to the OMA in private before, these public hearings would not be necessary. I think what you mean is that it would not be necessary in terms of the OMA's concerns but they still would be necessary for other people's concerns.

Dr Makerewich: Perhaps, but we as physicians are just absolutely shocked. What is trying to be accomplished here? The privacy and the confidentiality reek of a major physician fraud going on and I don't think that's the case.

I'm sorry, physicians are not unique. Everybody's angry at the government at this point. The teachers and labour unions and everybody else have been equally affected, so I don't think we have exclusive rights in that regard. When it comes down to it, many of the concerns here seem to have been—we don't know where they came from. Did they come from faceless bureaucrats? Did they come from people who have had an axe to grind in the past? What is trying to be accomplished here?

We're supposed to have a tool box. The government says they want to have a tool box. What are they fixing? What do they need to fix? Why do they need the tools that they say they need to fix this? Isn't a handshake and cooperation and co-management the way to go?

Mr Clement: You ask a lot of questions there, but do you think that the system is perfect right now in health care or that it needs to be fixed?

Dr Makerewich: The system is never perfect.

Mr Clement: I'll do a preface, because there is some reference to what you have said as doctors. We've heard a number of times from a number of different doctor presenters about how you are really life givers, no question about it. But you're also business people. You have to run an office; you have to pay the bills.

Dr Makerewich: We have fiscal realities.

Mr Clement: Sure, and you give something very important to the community but you have to do it in a context that makes sense for you as an individual, you as a family person, you as a practitioner. I think we all

understand that.

Are we coming to the point that there is some inherent tension in the way we have constructed our health care system in Canada, which is, I would say, a unique system but it's not the only system in the world? Is there an inherent tension there between doctors as life givers? We would like to have that service available to everyone through a socialized system of some sort. It's not like British health care but it is something—

Dr Makerewich: Which also has a private safety valve.

Mr Clement: That's right. Sorry, that's true, but national health in its original incarnation. We've got that on the one hand. We want those services. We want them available to everyone at any time of the day or night in every community. Is there an irreconcilability of that concept with the concept that we've tried to inject into our version of the health care system in Canada where doctors are not employees? That was the original incarnation. They're not employees. They provide a fee for service. Is there an irreconcilability there that you're sensing?

Dr Makerewich: The idea of infinite services with finite resources is certainly unreasonable and insupportable, increasingly insupportable with borrowed money.

Mr Clement: That's what I was trying to get at when I was saying there are some tensions in the status quo.

Dr Makerewich: With all the cutbacks that have occurred, I can assure you, sir, that doctors have been the only thing that has continued to make this system work. It would have collapsed years ago had we not gone the extra mile and done what we're doing now and not being paid for what we used to be paid for five years ago. It's not just about money. We love our work. We love serving our patients as well.

Mr Clement: Yes, and I wasn't trying to suggest it was just about money, which is why I prefaced it by saying you are life givers.

Dr Makerewich: I understand that, sir.

Mr Clement: You provide an essential part of our health care system.

That seems to suggest to me that there is a bit of tension there. Maybe there always was and it was up to government to grapple with that inherent tension in the system to ensure that doctors felt a part of the system, that they felt they were not just employees of the state. But at the same time government had a mandate to provide as many services as possible in the health care field to as many people as possible as many times as possible.

Maybe the mix is out of whack now or maybe circumstances have occurred over the last 20 or 30 years that have forced it be out of whack. Am I off in the wrong direction here?

Mr Makerewich: When medicare was introduced into Ontario—and correct me if I'm wrong; I believe it was Mr Robarts—I don't think he was a willing participant at the beginning, but when he finally got into this, I believe the term or phrase that was given to doctors was, "You practise medicine but just send us the bill." I think things have changed since then.

Mrs McLeod: Mr Chairman, since we have a number

of questions, I hope we'll have fully as much time as the Conservative side has had on this issue.

The Chair: You know that I'm always fair.

Mrs McLeod: One of the presentations began by suggesting that if there had been consultation with physicians before this bill was presented, we would not have the bill in front of us. It would be nice to think that might have been true. I think in fact it would not be true, because this bill is not about restructuring health care. There was no desire to seek rational and logical discussion about how we can manage to provide health care in the most cost-effective way. This bill is about cuts. It's about finding precisely \$1.5 billion in cuts in health care and finding it as quickly as possible.

I respect that one of the solutions you offer as an alternative might be a charge to patients. It's not one I happen to agree with. I think you would find that even if that had been proposed before Bill 26, the government might have been reluctant to accept it. If in fact the government is prepared to go that route or would be prepared to go that route, I suggest that we step down and let them say that now, because we'll have a really good debate and they will indeed make news by the end of the day.

But I don't think they would go that route. Therefore, I think we're back to discussing how we can provide health care in a way that allows us to offer that health care, quality health care regardless of ability to pay, and to manage that even in difficult financial times.

The government's toolkit is what they've offered—Bill 26. One thing they've done, they will continue to delist but they will set physicians' fees at zero—delisting by another name—and there will not be consultation with the OMA. We've seen the evidence of that.

One of the other tools, and there are many of them in here, is not just to take away the ability to appeal if you have been denied payment for a service rendered, but in fact for the government to prescribe the conditions under which health care can be provided, to prescribe what's medically necessary and at what terms and conditions.

I would ask you how comfortable you are with those kinds of powers being exercised by a government whose goal is to make cuts, to find savings in the system, and whether you think the government can exercise a judgement after the fact about what was medically necessary, and what that does to your clinical judgement when you're in the office with a patient.

Dr Smith: This could amount to Mike Harris's Vietnam. If he picks 20,000 fights with 20,000 doctors, they're going to bog down so fast that it'll be a nightmare for them. It's just not a practical approach. I have trouble micromanaging myself. I'm managing my practice, one doctor. It's tough. You try to manage 20,000 of us and you're going to have more headaches than you know what to do with.

Dr Reddy: I raised that issue in my submission.

Mrs McLeod: You did indeed.

Dr Reddy: I answered that question. This is a very objectionable part of the legislation. It is totally inequitable, the ministry giving us the guidelines for treatment, our clinical conditions, where and what to treat.

Failure of sound system.

Dr Makerewich: Could I make a comment as well? You asked for a level of comfort. I think our presence here bespeaks that, otherwise we wouldn't be here sharing this lovely time with you. I'm sure you're tired just like we are.

We all keep talking about preserving the system. I'm sorry there are shrinking finances; I'm sorry we have a federal problem, we have a provincial problem. There are decreasing funds. The bankers are starting to call their loans and get very worried about how we're going to manage economically and whether our Canadian dollar is going to collapse or not.

We've got to do something about the deficit. There's no problem in that way, from physicians certainly, but I think for us to continue the dream and the social experiment of the Canada Health Act, and what T.C. Douglas and Emmett Hall started, I'm sorry, but you have to look at the experiences elsewhere in different countries and see how they've dealt with it. They've had different solutions as well. I'm sure we're going to agree to disagree, but the way it's going now I see nothing but a slope downwards.

What is your end point in terms of rationalizing the efficiency of the system as the feds continue to cut back? What is the end point? Where do we stop before people say: "Finally we've gotten as efficient as we can. We can't afford any more"? Unless we start injecting some private money into the system and making patients more accountable—there is terrific patient abuse out there. Just talk to any emergency physician who has somebody come in looking for some aspirins because it's cheaper to come to emergency than to go to a drugstore and buy some. There's terrific abuse out there. I can assure you that it's not the doctors who are abusing the system, but there is a problem and we'd like to help.

Mrs McLeod: There's no question that there's a challenge to be able to preserve a system that we consider to be at this point in time one of the best in the world, and the challenge could only be met in a collaborative way.

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Dr Makerewich: With borrowed money, I might add.

Mrs McLeod: On that particular borrowed money note, if I don't turn to my colleague he will speak over top of me.

Mr Bradley: Speaking of borrowed money, I see on page 2 of your brief, "Doctors...fully support the fiscal objectives of the Harris government to reduce and eventually eliminate the deficit." Are you aware that this government, while they're cutting health care services, intends to borrow \$20 billion more over the next five years, paying \$5 billion in additional interest to give you and me a 30% tax break?

Dr Makerewich: Is that a matter of meeting their campaign promise then? So they're actually extending the debt? I wasn't aware of that. Thank you.

Mr Bradley: That's correct. It's right in the Common Sense Revolution. Look right in their numbers. That's where I got it: \$20 billion will be borrowed—

Mr Clement: That is their interpretation.

Mrs Pupatello: Your numbers, Tony.

Mr Clement: No.

Mr Bradley: —additional dollars, in order to finance

a tax cut. Do you think that is as productive a use of the finances of this province as either addressing the deficit or reducing the cuts to the health care system?

Dr Smith: The tax cut is not popular. I haven't heard anybody speak in favour of it.

Mr Clement: Unbelievable.

Mr Bradley: I appreciate that answer. It is something I'm hearing more and more, even from people who, as you point out here, in many ways support the thrust of the present government of Ontario. When they find out that the government is going to have to borrow money—add to the debt—to be able to give you and me a tax break, they often say, "I would either like you to address the deficit or I would like you to not cut as deeply in our health care system." Comment?

Dr Makerewich: We all have problems with the debt. I have problems with this so-called beautiful Canadian universal access system that was financed by our grandchildren and our great-grandchildren. That's fiscal reality for you.

Dr Reddy: Certainly what you said, that they have to borrow the money to pay the tax refunds, we were at least not aware of this fact. I think this is a matter of concern, as I see it. Certainly, we would like to see deficits reduced, but not with borrowed money to pay a tax refunds. This needs further clarification by the present government, I suppose.

Mrs Caplan: I'd like to address the Americanization aspect of Bill 26. You compared, I thought very accurately in your presentation, the fact that the United States spends 14% of their gross domestic product; we spend 10%. The United States is categorized by insurance companies that have managed-care organizations, fee-for-service. They also have copayment, user fees, deductibles, and patients pay if they have money; if they don't, they either don't get service or they go to emergency. That's one of the reasons it's so wildly expensive there.

One of the features of the American system that I'm very concerned about that Bill 26 will permit, and I'm not sure that we really are aware of the implications—Dr Reddy, your initial presentation I think alerts us to that—is that in this bill the cabinet defines "medical necessity"; the minister has the power to share patient records and information and the additional powers allow them to come in after the fact to say that they will not pay for anything that wasn't "medically necessary."

All those features are features of American managed-care organizations that require advanced approval before you do anything. "We don't pay you if you didn't get advanced approval or if we deem it wasn't medically necessary," is American managed care. They determine what is "medically necessary." They have to share

information in order to be able to do that and there's a 1-800 number that you call to get that advance directive. It's exactly the take that my colleague Ms Papatello addressed. There's actually an article from the New York Times, and I read this quote in that says, "They're basically moving to a US managed-care model." Who said this? Peter Coyte, professor of health administration from the University of Toronto. A spokesman from the ministry confirmed and said, "Some very basic management is finally being incorporated into the way we're spending our money."

How many people do you think realize that's what Bill 26 means?

Dr Makerewich: I have a unique perspective. I'm New York state licensed and I practise in the United States as well as in Canada. I've seen the system over there and I also know that the CEOs of some of these HMOs are making \$3 million and \$4 million a year. It's a for-profit system, thank you. Yes, I've been through the billing restrictions and I've seen a lot of that. I'm still practising in Canada. I love this country, I choose to stay here, but I have a foot in the door over there and I practise in both places right now because I happen to live in a border town. None the less, I'm not sure about that comparison to a managed-care system. I don't think there's anybody in the government who's going to be making \$3 million or \$4 million a year. I think that's a very unique way of looking at that situation.

The way that the American system works now is the competition, the overpopulation of doctors, is so much that physicians, number one, are bound by anti-trust legislation. They can't even talk to each other over there; it's illegal. They can't form an OMA over there. They have an American Medical Association, they have a New York State Medical Society, but for them to talk about fees is illegal. If a lawyer found out about that, they could be in big trouble. Even just talking about fees is anti-trust.

Secondly, if they don't take the fees, then there are four others behind them who will take less and less and less. They're at each other's throats there. Physician competition there is very keen and it's responsible for the fees ratcheting down over there. There have been major, major cuts in fees in the American system, and I'm seeing that over there now. In fact, I've offered some of my colleagues jobs in Canada if things get too tough.

The Chair: Thank you, doctors, very much for your interest in being here tonight. We really appreciate your being here and your interest in our process.

Dr Makerewich: Thank you. I enjoyed it.

The Chair: We stand adjourned until tomorrow in Hamilton.

The committee adjourned at 1736.

ERRATUM

No.	Page	Column	Line	Should read:
G-5	G-174	2	55	Mr Clement: That's a very good point and certainly

STANDING COMMITTEE ON GENERAL GOVERNMENT

Chair / Président: Carroll, Jack (Chatham-Kent PC)

*Carroll, Jack (Chatham-Kent PC)

Danford, Harry (Hastings-Peterborough PC)

Kells, Morley (Etobicoke-Lakeshore PC)

Marchese, Rosario (Fort York ND)

Sergio, Mario (Yorkview L)

Stewart, R. Gary (Peterborough PC)

**In attendance / présents*

Substitutions present / Membres remplaçants présents:

Caplan, Elinor (Oriole L) for Mr Sergio

Clement, Tony (Brampton South / -Sud PC) for Mr Kells

Ecker, Janet (Durham West / -Ouest PC) for Mr Stewart

Johns, Helen (Huron PC) for Mr Danford

Lankin, Frances (Beaches-Woodbine ND) for Mr Marchese

Also taking part / Autre participants et participantes:

Agostino, Dominic (Hamilton East / -Est L)

Bradley, James J. (St Catharines L)

Froese, Tom (St Catharines-Brock PC)

Hudak, Tim (Niagara South / -Sud PC)

Kormos, Peter (Welland-Thorold ND)

McLeod, Lyn (Fort William L)

Pupatello, Sandra (Windsor-Sandwich L)

Clerk / Greffière: Grannum, Tonia

Staff / Personnel: Drummond, Alison, research officer, Legislative Research Service

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